

Exhibit UU

THE PERDUE SAVINGS PLAN SUMMARY PLAN DESCRIPTION

For associates in these Benefit Groups:

- **1 – Salaried/Exempt**
- **2 – Administrative/Technician – Hourly/Non-exempt**
- **3 – Skilled Labor – Hourly/Non-exempt, Piece Rate**
- **4 – General Labor – Hourly/Non-exempt, Piece Rate**

Separate summary plan descriptions of this Plan exist for associates who are union members.

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de ahorros de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-547-7754 para obtener ayuda.

Revised July 1, 2021

Preface

This is a Summary Plan Description (SPD) of the benefits available to eligible non-union associates under The Perdue Savings Plan (“the Plan”). It summarizes the benefits available under the terms of the Plan that are in effect as of July 1, 2021. It explains in non-technical language how the Plan works, and it replaces all prior SPDs for the Plan.

Contribution Types

There are a number of contribution types currently made under the Plan. Other contribution types were made in the past. The Appendix at the end of this SPD has a full list of contribution-type subaccounts maintained under the Plan. Not all sections of the SPD apply to each contribution type. For any questions, please call the Principal Contact Center at 1-800-547-7754.

IRS Annual Dollar Limits

There are a number of IRS annual dollar limits that apply to the Plan. Each year, these limits may change based on inflation. For updated annual dollar limits, please see the Appendix at the end of this SPD.

More detailed information is provided in the plan document, a copy of which is available upon request. If there is a difference between how the SPD and the plan document describe the eligibility rules and the benefits being provided under the Plan, the plan document will control and govern the operation of the Plan.

In this SPD, Perdue Farms Inc. is referred to as the “Plan Sponsor,” each of Perdue’s related companies is referred to as a “Perdue Company,” and each Perdue Company that has adopted the Plan to allow its eligible associates to participate is referred to as a “Participating Company.”

The Plan Sponsor has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document).

If you have questions regarding your benefits, call the Principal Contact Center at 1-800-547-7754. Participation in the Plan is neither an offer nor a guarantee of future employment.

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Introduction

The Plan enables you to save money for retirement while taking advantage of current tax laws. Not only do your earnings grow on a tax-deferred basis (you don't pay taxes on your earnings until you withdraw them from your Plan account), you can reduce your current income taxes just by making before-tax contributions to the Plan. And, when you make before-tax contributions or Roth contributions, your employer matches a portion of those contributions once you meet the eligibility requirements.

Although the money in your account is meant to fund your retirement, you may be able to access some of the funds before termination of employment through loans or withdrawals (when you have a severe financial hardship or reach age 59½, or otherwise).

Eligibility and Enrollment

This section outlines the Plan's rules of eligibility for associates to participate.

Eligible Associates

You are eligible to participate in the Plan if you are an eligible associate of a Participating Company. If you are uncertain whether your employer is a Participating Company, call the Principal Contact Center at 1-800-547-7754.

You are an eligible associate if (1) you are classified by a Participating Company as an associate working on a regular basis, and (2) you are classified as being in Benefit Group 1, 2, 3 or 4, and are not:

- In a job class covered by a collective bargaining agreement, unless your collective bargaining agreement provides for your participation in the Plan;
- A leased employee;
- Classified by your employer as a contract worker, independent contractor, or temporary employee, whether or not you are on your employer's W-2 payroll or are determined by the IRS or others to be a common-law employee;
- A non-resident alien with no income from sources within the U.S.;
- Performing services for a Participating Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of a Participating Company; or
- Performing services for a Participating Company as part of a work-release program.

Get the Most from the Plan

If you are an eligible associate, you must contact Principal by calling 1-800-547-7754 to enroll in the Plan or enroll online at www.principal.com. To use the Plan to your best advantage, you must contribute to the Plan regularly. Read on to learn how.

When You May Contribute

In order to begin saving for your future by contributing to your Plan account, you must also:

- Be at least 21 years old; and
- Have worked for a Perdue Company for at least 30 days.

When You May Receive Company Matching Contributions

In order to receive Company matching contributions to your Plan account, you must also:

- Be at least 21 years old; and
- Have completed at least one year of "eligibility service."

You become eligible to receive Company matching contributions on the first day of any calendar quarter (i.e., January, April, July, October) after (or upon which) you meet the above requirements.

To receive Company matching contributions, you must make 401(k) deferrals (before-tax or Roth contributions) to the Plan. You do not need to make contributions to the Plan in order to receive Company discretionary contributions.

Eligibility Service

You complete a year of eligibility service if you are credited with at least 1,000 hours of service during the 12-month period that ends on:

- The first anniversary of your date of hire with a Perdue Company, or
- Any December 31 (the last day of the “Plan Year”), if you did not complete at least 1,000 hours of service during the 12-month period following your date of hire.

Examples: Mr. Jones begins employment on February 1, 2021. By January 31, 2022, he has completed at least 1,000 hours of service, so he has completed the eligibility service requirement on that date. Mr. Jones will begin to receive Company matching contributions as of the next quarterly entry date (April 1, 2022).

Mr. Smith begins employment on February 1, 2021, but has not completed 1,000 hours of service by January 31, 2022. The next 12-month evaluation period is calendar year 2022. Mr. Smith completes at least 1,000 hours of service during calendar year 2022, so he has completed the eligibility service requirement on December 31, 2022. Mr. Jones will begin to receive Company matching contributions as of the next quarterly entry date (January 1, 2023).

Hour of Service

You are credited with an “hour of service” for each hour you are either paid or entitled to be paid by a Perdue Company. You may be credited with hours of service for time you do not work and are not paid, such as a layoff of less than one year and approved leaves under the Family and Medical Leave Act or the Uniformed Services Employment and Re-employment Rights Act. Except for approved military leaves, you may not be credited with more than 501 hours of service for a single period that you are not working.

Break in Service

You have a one-year break in service for any calendar year in which you are credited with 500 hours of service or less.

Naming Your Beneficiary

A beneficiary is the person who receives the money in your account if you die. You should name a primary beneficiary to ensure that your benefits are distributed according to your wishes. It is also important to name a contingent beneficiary who will receive your benefits if your beneficiary dies before you.

You may designate (or change) your primary and/or contingent beneficiary online by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

If you are married and at any time you want to name someone other than or in addition to your spouse as your primary beneficiary, your spouse must give consent, witnessed by a notary. This is required by federal law.

If you are not married and you do not name a beneficiary, no valid designation of beneficiary exists, or your beneficiaries are no longer living, the Plan will pay your account balance to your estate.

Contributions to the Plan

The Plan and IRS rules govern both the type and amount of contributions that you and your employer may make to the Plan.

Your Compensation

Both you and your employer contribute to the Plan to build your benefit. The amount you contribute is a percentage of your “compensation.” Your compensation is your pay from a Participating Company reportable on Form W-2, Box 1, plus the before-tax contributions you make toward employer benefit programs. But your compensation does not include amounts you receive from a Participating Company as fringe benefits, taxable welfare benefits, expense allowances or severance pay.

In addition, the IRS limits your compensation for purposes of Company contributions to the Plan. This means that your Company matching contributions for a year will not exceed the annual compensation limit multiplied by the matching contribution rate. See the Appendix for the annual compensation limit.

The IRS annual compensation limit does not impact your ability to make before-tax, Roth, or after-tax contributions (which are subject to the other limits described in this SPD).

Annual Contribution Limits

The IRS also limits the amount that **you and your employer** may contribute to the Plan in a calendar year. This limit is the lesser of:

- 100% of your compensation; or
- An annual dollar limit. This annual dollar limit applies to contributions to all of the Perdue Company tax-qualified plans in which you participate during a calendar year; see “Contributing to Another Tax-Qualified Plan in the Same Year.” See the Appendix for the annual contribution limit.

Please note: Rollover contributions (described below) do not apply to these annual limits.

Your Contributions to the Plan

When you are eligible to contribute to the Plan (see “When You May Contribute”), you may contribute a percentage of your compensation to the Plan from each Participating Company paycheck. You may contribute as little as 1% or as much as 75% of your compensation, in whole percentages, as before-tax deferrals, Roth deferrals, and/or after-tax contributions. You may change the amount you contribute at any time.

Your Before-Tax 401(k) Deferrals

Your before-tax 401(k) deferrals come from your pay before federal (and most state and local) income taxes are figured. Unlike your before-tax contributions to other employer benefit plans, your 401(k) deferrals *are* subject to Social Security and Medicare taxes (FICA withholding).

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as 401(k) deferrals (before-tax and Roth combined). See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals (before-tax and Roth) (not your after-tax contributions).

Your Roth 401(k) Deferrals

Your Roth deferrals come from your pay after federal, state and local income taxes are figured, and are subject to Social Security and Medicare taxes (FICA withholding). Unlike before-tax contributions, these contributions and their earnings are not taxable when they are distributed to you, as long as certain tax law requirements are met. This means that this portion of your retirement savings is able to grow tax-free and that you do not have to pay taxes on it when you receive the money, as long as certain tax law requirements are met.

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as 401(k) deferrals (before-tax and Roth combined). See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals and Roth deferrals only (not your after-tax contributions).

Your After-Tax Contributions

Your after-tax contributions are deducted from your pay after taxes are figured.

If you are a “highly compensated employee” as defined by IRS rules, your after-tax contributions may be limited in order for the Plan to meet non-discrimination tests. You are a highly compensated employee if your compensation from Perdue Companies for the prior year exceeded the threshold amount specified by the IRS for the year. See the Appendix for the highly compensated employee threshold amount. If the Plan fails a non-discrimination test and your after-tax contributions must be limited, you will be notified.

Note: After-tax contributions are not matched by your employer.

Your Rollover Contributions

You may make a rollover contribution to the Plan at any time. Rollover contributions are transfers of money from another tax-qualified plan – such as a former employer’s 401(k) plan or an individual retirement account – to this Plan. Rollover contributions must be transferred from your former plan or provided by you within 60 days after you receive the distributions from your former plan. You may make a rollover contribution of pre-tax, Roth, or after-tax funds from a former employer’s plan, and you may make a rollover contribution of pre-tax funds (but not after-tax funds or Roth funds) from an individual retirement account. If you wish to make a rollover contribution of Roth or after-tax funds from a former employer’s plan, the funds must be transferred directly from your former employer’s plan.

Amounts you transfer to the Plan as a rollover contribution do not count against any Plan or IRS contribution limit, and they are not matched by any Company contribution.

The tax laws and rules involving rollovers are complex. Whether you can, or even should, roll over an amount you previously received is a question you should discuss with your personal tax advisor, because each person’s circumstances differ.

For more information or to make a rollover to the Plan, call the Principal Contact Center at 1-800-547-7754.

Note: Rollover contributions are not matched by your employer.

Example: Ms. Jones is eligible to participate in the Plan. Ms. Jones has a personal individual retirement account (IRA) with a balance of \$50,000 of pre-tax funds. In addition to making 401(k) deferrals and receiving matching contributions, she may have her IRA custodian transfer the \$50,000 to her Plan account, as a rollover contribution. The transferred funds (as adjusted for earnings and losses) will be separately accounted for as a subaccount within her Plan account. Her rollover contribution will not affect the amount she is otherwise eligible to contribute as 401(k) deferrals for the year, and will not be matched.

Your Catch-Up Contributions

During any calendar year in which you are age 50 or older, you may make catch-up contributions to the Plan. These are before-tax contributions, but they do not count toward the IRS dollar limit that generally applies to your 401(k) deferrals, the Plan's 75% of compensation contribution limit, or the IRS overall annual contribution limit (100% of your pay or the annual contribution limit for the year).

The IRS has a dollar limit for catch-up contributions. Therefore, if you are age 50 or older, you may contribute up to the combined amount of the annual deferral limit and the annual catch-up deferral limit. The IRS allows catch-up contributions to allow people to save more for retirement in their later working years.

See the Appendix for each of the limits discussed in this section.

Note: Catch-up contributions are matched by your employer on the same terms as other before-tax contributions.

Tax Credit for Your Contributions

You may be entitled to a tax credit for your contributions to the Plan, in addition to the tax savings from these before-tax contributions. The federal tax credit is available only if your "adjusted gross income" for tax purposes is below certain limits, which are set forth in the Appendix.

This tax credit ranges from 10% to 50% of the first \$2,000 (\$4,000 if married filing jointly) you contribute to the Plan (either before-tax or after-tax) for the calendar year, depending on how you file your tax return. You must meet certain conditions to qualify for this tax credit; please consult your tax advisor.

Company Contributions to the Plan

Your employer also contributes to your Plan account. Some Company contributions are made automatically, but some are made strictly at your employer's discretion.

Company Matching Contributions

When you make before-tax or Roth contributions to the Plan, your employer makes matching contributions to your Plan account once you have met the eligibility requirements. These contributions are considered "safe harbor" matching contributions under IRS rules.

Your employer provides a match of 100% of your before-tax and/or Roth contributions each pay period, up to 5% of your eligible pay for the pay period. The match is calculated each pay period as follows:

If you are eligible for the match from the first day of the Plan Year: Each pay period, your employer will determine how much total eligible compensation you have received for the year (including that pay period), and how much you have contributed as before-tax and/or Roth contributions for the year (including that pay period). Your employer will provide a match, each pay period, sufficient to bring your total, year-to-date match up to your total, year-to-date before-tax and/or Roth contributions, subject to the limit of 5% of your year-to-date eligible compensation. See the Appendix for an example.

If you become eligible for the match during the Plan Year: Each pay period, your employer will determine how much total eligible compensation you have received for the year *on or after your match eligibility date* (including that pay period), and how much you have contributed as before-tax and/or Roth contributions for the year *on or after your match eligibility date* (including that pay period). Your employer will provide a match, each pay period following your match eligibility date, sufficient to bring your total, year-to-date match up to your total before-tax and/or Roth contributions *made on or after your match eligibility date*, subject to the limit of 5% of your eligible compensation received for the year *on or after your match eligibility date*. See the Appendix for an example.

As explained above in the section entitled “Your Compensation,” your annual match cannot exceed the amount determined by applying the match formula to the IRS annual compensation limit (set forth in the Appendix).

Company Discretionary Contributions

In past years, Participating Companies made discretionary contributions to the Plan. Discretionary contributions are made to the Plan account of each eligible associate who is employed by a Participating Company as of the end of that calendar year. Former eligible associates who died, retired, or terminated employment during the year due to disability are eligible to receive a pro-rated Company discretionary contribution, based on their number of full calendar months of employment during the year.

The amount of the Company discretionary contribution (if any) for any calendar year is determined by the Plan Sponsor based on profitability for the year, and it is contributed as a fixed dollar amount for every eligible participant. Your employer will notify you if a discretionary contribution will be made for any given year.

Note: You are not required to contribute to the Plan to receive a Company discretionary contribution.

Managing Your Plan Account

The Plan's Trustee, Principal Trust Company, holds in trust all the assets of the Plan. When you become an eligible associate, Principal sets up a separate account in the Plan for you. Your Plan account is used to hold your Plan benefit.

Investing Your Plan Account

As a participant, you are responsible for directing the manner in which the funds are invested. Because the Plan is a "tax-qualified plan" under IRS rules, you defer paying taxes on the investment earnings while they remain in your Plan account.

You may invest your Plan account among a menu of investment funds. You can place 100% of those amounts in one fund or spread your investment in multiples of 1% among all the funds – just make sure your total investments add up to 100%.

You may change your investment decisions at any time. You also may make separate investment elections for your current account balance and for your future contributions to the Plan. Any changes you make become effective as soon as administratively feasible. Make your investment elections online at www.principal.com, or by calling the Principal Contact Center at 1-800-547-7754. Expenses of administering the Plan and trust may be paid from the trust fund. Fees and costs associated with the investment of your account may be charged to your Plan account.

Short-Term Trading Is Prohibited

The Plan is designed for retirement savings, not for short-term investments. The Plan Administrator and Trustee monitor investment changes and have the right to place restrictions on participants whose trading patterns appear to be short-term only and not in keeping with the Plan's intent.

In addition, some investment funds may have certain restrictions or charge a "short-term trading redemption fee" when money is transferred from a fund shortly after being deposited. Please see the prospectus of the investment funds you choose to understand any restrictions or fees related to short-term trading.

Information about the investment funds is available on the Principal website at www.principal.com.

The "Default" Investment Fund

If you do not choose how to invest your account, your account will be automatically invested in a qualified default investment fund that meets the requirements outlined in the Department of Labor's regulations. If you remain in the default investment fund, you may transfer out of this investment to another Plan investment fund at a later time.

How to Make Your Investment Choices

By phone: Call the Principal Contact Center at 1-800-547-7754.

Online: Use the secure Principal website at www.principal.com.

Choosing Investment Funds Is Your Responsibility

The Plan is intended to comply with Section 404(c) of the Employee Retirement Income Security Act (ERISA) and the Department of Labor's final regulation on "qualified default investment

alternatives” (QDIAs). This means you are legally responsible for your investment choices. Because the Plan complies with this section of ERISA, the fiduciaries of the Plan, including the Plan Sponsor, the Trustee, and the Plan Administrator, will be relieved of any legal liability for any losses that are the direct and necessary result of the investment directions that you give.

When you direct the investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your Plan account does not share in the investment performance of other participants who have directed their own investments.

Your Plan account will be updated for investment earnings or losses each day that the applicable investment markets are open.

The Plan Administrator has established participant direction procedures setting forth investment choices available to you, the frequency with which you can change your investment choices, and instructions on how you can obtain other important information on directed investments. These procedures are provided to you when you enroll in the Plan. It is important that you carefully follow the election procedures in order to ensure that your elections are properly indicated. If you have questions about these procedures, contact the Principal Contact Center at 1-800-547-7754 or by logging onto www.principal.com.

You are not required to direct investments. If you choose not to direct investments, then your account will be invested in the “default” investment fund (as described above).

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. There are no guarantees of performance. The Plan Sponsor, the Plan Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

You can check your account balance, make investment elections or changes or request information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

A personal identification number (“PIN”) is assigned to each Plan participant. This PIN and your Social Security Number will allow you to access your account via the secure website (www.principal.com). You also can reach an account representative by phone at 1-800-547-7754.

Receiving Plan Investment Information

To comply with Section 404(c) of ERISA and the 404(c) Regulations, the Plan names the Plan Administrator – the Perdue Farms Inc. Investment Committee – as the fiduciary (“404(c) Fiduciary”) responsible for providing Plan investment information upon request of you or your beneficiary. You may obtain information regarding your investment fund options by contacting the Principal Contact Center at 1-800-547-7754.

In addition to the material you receive from the Plan, you have the right to request additional information (available at no cost) to help you decide which investment options to select. The information you may request includes:

- A description of the annual operating expenses of each investment alternative (for example, investment management fees, administrative fees) which reduce your rate of

return, and the aggregate amount of expenses expressed as a percentage of average net assets of the investment alternative.

- Copies of any prospectuses, financial statements and reports, and any other materials relating to the investment alternatives, to the extent this information is provided to the Plan.
- With respect to each investment alternative, a list of assets that make up the portfolio, the value of each asset (or the proportion of the investment alternative to which it belongs); and with respect to each asset which is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term and the rate of return on the contract.
- Information concerning the value of shares or units in the investment alternatives, and information about the past and current investment performance, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment alternative held in your Plan account.

Vesting in Your Plan Account

“Vesting” means your right to receive the value of a specific part of your Plan account as a benefit from the Plan. Once you are vested in a portion of your Plan account, that portion may not be forfeited or taken from you. But please note that the value of the vested portion of your Plan account may go up or down, based on the value of the Plan’s investment funds you have chosen.

You are always 100% vested in any before-tax, Roth, or after-tax contributions that you make to the Plan, as well as in any matching contributions that your employer makes to the Plan on your behalf (and any investment earnings or losses attributable to those contributions).

You will become vested in any Company discretionary contributions in your Plan account—and the investment earnings or losses attributable to those discretionary contributions—over time, based on your “vesting service.” Specifically, if you complete 3 years of vesting service, you will become fully vested in any discretionary contributions.

Other vesting schedules applied to prior contribution types. For information about those schedules, please call the Principal Contact Center at 1-800-547-7754.

In addition to these schedules, you are automatically 100% vested in your Plan account if you remain employed by a Perdue Company on the date you:

- Reach age 65;
- Are considered totally and permanently disabled under a Perdue Company disability plan or Social Security; or
- Die.

Counting Your Vesting Service

You have a year of vesting service for each calendar year in which you are credited with at least 1,000 hours of service (see “Hour of Service”). In calculating your vested percentage, all service you perform for the Perdue Companies is generally counted. However, exceptions apply if you have a “break in service.” For vesting purposes, you have a break in service if you complete less than 501 hours of service during a calendar year. However, if you are absent from work for certain leaves of absence – such as maternity or paternity leave – you may be credited with up to 501 hours of service in order to prevent a break in service (see “Hour of Service”).

Returning to Employment After a Break in Service

If you have not made 401(k) deferrals and have no vesting (0% vested) in the Company discretionary contributions in your Plan account and have a break in service of five years or more, all the service you earned before the five-year break no longer counts for vesting purposes. So if you return to employment after a break in service of five years or more, you will be treated as a new associate (with no prior service) for purposes of determining your vesting service in the Plan.

If you have made 401(k) deferrals, or if you are vested in the Company discretionary contributions in your Plan account, and have a break in service, all your years of vesting service are restored when you return to employment.

The Plan Administrator monitors the break in service rules and can provide you with additional information on their effect.

How Vesting Affects Your Benefit

If your employment ends when you are less than 100% vested in the Company discretionary contributions in your Plan account, you forfeit the non-vested portion of those contributions (and associated investment returns). The Plan uses forfeitures to pay the Plan's expenses and administrative fees. If forfeitures remain after those fees are paid, the Plan uses remaining forfeitures to pay Company matching contributions or discretionary contributions for other participants.

If you return to employment after forfeiting any part of your Plan account, the amount you forfeited will be restored to your Plan account if:

- Your break in service is less than five years; *and*
- You repay any distribution you received from the Plan when your employment ended within five years from the date of your re-employment.

Receiving Money from the Plan While You Are Working

The purpose of the Plan is to help you save money for retirement years, but it includes features that allow you to receive money from your Plan account while you are still working for the Perdue Companies.

Plan Loans

You may borrow from the vested portion of your Plan account and use the money for any purpose. The Plan has a written loan policy that explains the rules governing Plan loans in detail; for a copy, call the Principal Contact Center at 1-800-547-7754.

Your Plan loan cannot be more than the lesser of:

- One-half of your vested Plan account at the time of the loan; and
- \$50,000, *minus* your highest outstanding Plan loan balance during the past 12 months.

The minimum loan allowed by the Plan is \$1,000. You may have only one Plan loan at a time. No more than two loan applications may be approved during any calendar year and a minimum of one month must pass between the dates that one loan is paid off and a new loan is applied for. A \$75 loan processing fee is charged for each loan from the Plan.

All Plan loans must be repaid within five years, with interest. You repay your loans by payroll deduction, but you may repay your loan in full, without penalty, with a cashier's check or money order made payable to Principal Trust Company, the Trustee.

Non-Hardship Withdrawals

You may withdraw certain funds from your Plan account if you meet the requirements set out by the Plan and/or the IRS. All or a portion of any withdrawal from your Plan account is taxable to you; see "Taxes on Your Plan Benefits" for details.

Tables in the Appendix of this SPD include short descriptions of current and prior plan accounts and the distribution options available for each account. For more information on which prior or current Plan contributions, if any, may be eligible for a non-hardship withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Age 59½ or Older

When you are age 59½ or older, you may withdraw money from the vested portion of these funds in your Plan account at any time, without proving a financial hardship:

- Your 401(k) deferrals (before-tax and Roth);
- Your rollover contributions;
- Company matching contributions; and
- Company discretionary contributions.

Taxes are withheld from your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

Tables in the Appendix of this SPD include short descriptions of current and prior plan accounts and the distribution options available for each account. For more information on which prior or

current Plan contributions, if any, may be eligible for an age 59½ (or older) withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Younger than Age 59½

If you are not yet age 59½ and you do not have a financial hardship, you may withdraw only the following funds in your Plan account:

- After-tax **matched** contributions you made to the Plan more than two years ago;
- After-tax **unmatched** contributions you made to the Plan;
- After-tax rollover contributions you rolled over to this Plan; and
- Rollover contributions you rolled over to the Coleman Natural Foods, LLC 401(k) Plan prior to January 1, 2013.

Taxes are withheld from the taxable portion of your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

Certain prior contribution types may also permit in-service withdrawal without a financial hardship; see the table in the Appendix of this SPD for details, or call the Principal Contact Center at 1-800-547-7754.

Hardship Withdrawals

You may make a hardship withdrawal of certain funds in your Plan account if you meet the requirements set out by the Plan and/or the IRS. Hardship withdrawals are allowed only when you need to pay:

- Medical expenses not covered by insurance, for you or your dependents;
- Costs directly related to the purchase of your home – but not for regular mortgage payments;
- College tuition, fees, and room and board expenses for you or your dependent for the next 12 months;
- Expenses to prevent your eviction or foreclosure on your home;
- Funeral or burial expenses for your parent, spouse or dependent;
- Expenses to repair uninsured damage to your home resulting from a natural disaster; or
- Expenses and losses (including loss of income) you incur due to a disaster declared by FEMA, if your principal residence or place of employment is located in an area designated by FEMA for individual assistance.

To qualify for a hardship withdrawal, you must show that you have first exhausted all other sources of funds to meet your need, including distributions (but not loans) from the Plan. You may withdraw only the amount needed to meet your financial need, including amounts you must pay in taxes and penalties on your withdrawal. The Plan Administrator requires documentation from a third party to justify your financial need.

Taxes are not required to be withheld from your hardship withdrawal, and it is not eligible for tax-deferred rollover.

Certain prior contribution types may also be eligible for a hardship withdrawal; see the tables in the Appendix of this SPD for details, or call the Principal Contact Center at 1-800-547-7754.

Receiving Your Benefit from the Plan

Because the Plan is designed to help fund your retirement, the Plan's benefits are payable when you reach age 65, the Plan's normal retirement age. But you may receive your benefit from the Plan before or after that date, depending on your personal circumstances.

The Plan pays benefits in a single lump sum. Also, you may take partial distributions of your account (subject to the Plan's administrative procedures). If you participated in the Plan before July 1, 2000 and you previously received Money Purchase Plan contributions, you have different payment options available for a portion of your Plan benefit; see the section "Money Purchase Plan Benefit Payments" for details.

To file a claim for benefits from the Plan, contact the Principal Contact Center at 1-800-547-7754. See the section "Claims" for more information.

When You Retire or Become Disabled

You may receive your Plan benefit when you retire at age 65 or older, or when you become totally and permanently disabled under the terms of a Perdue Company disability plan or Social Security. If you reach age 65 or incur a disability while you are employed by a Perdue Company, you are 100% vested in your Plan account, and the full amount is payable to you as your Plan benefit.

When Your Employment Ends

If your employment ends before you reach age 65 and you are not disabled, you may receive the vested portion of your Plan account as your Plan benefit. You forfeit any part of your Plan account in which you are not 100% vested.

When your employment ends, Principal sends you information about how to receive your Plan benefit. You will have the option of rolling over your Plan benefit to another tax-qualified plan, as described in "Rolling Over Your Benefit to Another Plan."

The value of your Plan account determines your options for receiving your Plan benefit.

Options for Deferring Your Benefit

If your employment ends and you wish to defer receiving your Plan benefit, you may do so until you reach your "required beginning date" (see below). Call the Principal Contact Center at 1-800-547-7754 for more information about the "required minimum distribution" rules.

When Your Plan Account Is More Than \$5,000

If the value of your Plan account (excluding any rollover contributions into the Plan) is more than \$5,000 when your employment ends, you may receive your Plan benefit at any time, but generally not later than your "required beginning date" which is the April 1st of the year following the later of the year in which you attain age 72 (age 70½ if you reached such age by December 31, 2019), or the year in which you terminate employment. At that time, you may take a lump sum distribution, or partial distributions, as long as they are sufficient to meet the "required minimum distribution" rules. You continue to direct the investment of your Plan account, using the same investment options offered to all other Plan participants.

When Your Plan Account Is Between \$1,000 and \$5,000

If the vested portion of your Plan account is more than \$1,000, but not more than \$5,000 (excluding any rollover contributions into the Plan) when your employment ends, you must receive your benefit from the Plan. Principal will send you information about your options for receiving your benefit from the Plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If you do not tell Principal how you want to receive your Plan benefit, your Plan benefit will be rolled over to an individual retirement account (IRA). The Plan Administrator has chosen the Total IRA program, offered by The Mid Atlantic Trust Company, as the automatic IRA to receive your rollover. Your rollover funds will be invested in a type of investment designed to preserve principal and provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund), unless you elect other investments.

All fees and expenses related to this rollover IRA and the IRA investments will be allocated solely to you, as the IRA holder. You may transfer the IRA to another IRA of your choosing.

For more information regarding the Plan's automatic rollover provisions, the IRA provider and fees and expenses attendant to the IRA, call the Principal Contact Center at 1-800-547-7754.

When Your Plan Account Is \$1,000 or Less

If the vested portion of your Plan account is \$1,000 or less when your employment ends, you must receive your benefit from the Plan. Principal will notify you of your right to roll over your Plan benefit to a rollover IRA or another tax-qualified plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If You Die

If you have a balance in your Plan account when you die, the Plan will pay it to your beneficiary (described in "Naming Your Beneficiary"). Your beneficiary may make periodic withdrawals, or defer receiving your Plan benefit, but no longer than shown here (if you die after December 31, 2019):

- **When your beneficiary is your spouse**, he or she may defer receiving your Plan benefit until the *later of*:
 - The end of the first complete calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules;
 - The end of the calendar year in which you would have reached age 72 (your "required distribution date"), with annual distributions in amounts that satisfy the required minimum distribution rules; or
 - The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is an "eligible designated beneficiary" other than your spouse**, the Plan benefit must begin by the later of:
 - December 31 of the calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules; or

- The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is not an “eligible designated beneficiary”**, the Plan benefit must be distributed by the end of the tenth calendar year following the calendar year of your death.
- **An “eligible designated beneficiary”** is your surviving spouse, your child who has not reached the age of majority at your death, a chronically ill individual (as defined by the Internal Revenue Code), or any other individual who is not more than ten years younger than you.

Money Purchase Plan Benefit Payments

If you participated in the Plan before July 1, 2000, and you previously received Money Purchase Plan contributions, your benefit from those contributions only (your “MPP Account”) will be used to purchase an annuity (a guaranteed series of monthly payments for life) unless you elect otherwise. If you are married at the time of payment, your spouse must give written consent to any choice other than the Joint and 100% Survivor Annuity or the Joint and 50% Survivor Annuity. This written consent must be notarized or witnessed by a Plan representative.

These are the annuity options for your MPP Account:

- **Joint and 100% Survivor Annuity** – Pays a monthly benefit to you for as long as you live. When you die, 100% of that monthly benefit continues to your surviving spouse for life. *If you are married when you begin receiving your Plan benefit, this is the option that automatically applies, unless you and your spouse choose another option.*
- **Joint and 50% Survivor Annuity** – Pays a monthly benefit to you for as long as you live. When you die, 50% of that monthly benefit continues to your surviving spouse for life. The monthly benefit payable to you under this option will be larger than the monthly benefit from the Joint and 100% Survivor Annuity option.
- **Life Annuity** – Pays a monthly benefit to you for as long as you live. When you die, all benefits end. *If you are not married when you begin receiving your Plan benefit, this is the option that automatically applies.*

You may decline all of these annuity options and elect to have the balance of your MPP Account paid in a single lump sum or through partial distributions, by waiving your right to an annuity when you receive your lump sum or each time you receive a partial distribution. If you are married, your spouse must give written consent to your choice, and this written consent must be notarized or witnessed by a Plan representative.

Please note: If the vested portion of your Plan account is \$5,000 or less when your employment ends, your entire account balance, including the value of your MPP Account, will be distributed in a single lump sum, which you elect to receive in cash or as a rollover.

Rolling Over Your Benefit to Another Plan

If your employment ends and you take a distribution of the vested portion of your Plan account, you have the option to roll over your Plan benefit to another tax-qualified plan, such as a Rollover IRA or another employer’s tax-qualified plan, such as a 401(k), 403(b), or a governmental 457(b) plan.

There are two ways to make a rollover from the Plan:

Indirect Rollover

When you receive a distribution from the Plan, you have 60 days to roll over that distribution to another tax-qualified plan. If you wait more than 60 days to complete your rollover, the full value of your distribution from the Plan becomes taxable to you.

The Plan is required to withhold 20% of the distribution of your Plan benefit for federal income taxes. (Additional state-level mandatory tax withholding may also apply.) In order to defer taxes on the full value of your Plan benefit, you must roll over 100% of your Plan benefit within the 60-day limit. This means you will have to use other funds with your rollover contribution to make up the 20% withheld for taxes, otherwise the 20% withheld will become taxable to you.

Direct Rollover

You may avoid tax withholding by electing a direct rollover of your account to another tax-qualified plan or account. With a direct rollover, your funds are transferred directly to the new plan or account, and you do not take possession of them.

Taxes on Your Plan Benefits

The Plan is a “tax-qualified plan” under IRS regulations. This means that much of the money in your Plan account (other than Roth and after-tax contributions)—including Company contributions and investment earnings—is sheltered from income taxes until you take it from the Plan (and is further sheltered if you do a direct rollover as discussed above). This section describes how taxes affect your benefits when you receive them from the Plan, according to tax laws in effect at the time this SPD was written.

Ordinary Income Taxes

Before-tax deferral contributions, Company contributions, and their investment earnings are subject to federal, state and local income taxes upon distribution. Roth deferral contributions are income tax-free upon distribution, and their investment earnings may potentially be income-tax free upon distribution, if IRS requirements are satisfied (and if permitted by state/local law). After-tax contributions are tax-free upon distribution, but their investment earnings are taxable upon distribution. Taxation may be deferred through a rollover to another employer-sponsored retirement plan or an individual retirement account.

For distributions that are not directly rolled over, the Plan is required to withhold 20% of the taxable amount as federal income tax withholding. Additional state and local mandatory withholding may also apply.

Tax treatment and rollover rules are complex, vary based on contribution type and the type of account receiving the rollover, and are subject to change. You will receive additional information when you are ready to take a distribution, and should consult with a tax advisor for assistance.

Additional 10% Tax

If you receive a distribution from the Plan before you reach age 59½ – as a Plan benefit or as a hardship withdrawal – that distribution may be subject to an additional 10% federal tax for an “early distribution,” sometimes referred to as a “penalty tax,” if it is not rolled over. This additional 10% tax does not apply, however, if your distribution is:

- Paid due to your disability;

- Paid as a series of equal payments over your life or life expectancy (or your and your beneficiary's lives or life expectancies);
- Used to pay certain tax-deductible medical expenses;
- Paid directly to the government to satisfy a federal tax levy;
- Paid to you during a period of at least 180 days of active military duty; or
- Paid to an "alternate payee" under a Qualified Domestic Relations Order (see "Receiving a Qualified Domestic Relations Order").

More information about the additional 10% federal tax is found on IRS Form 5329.

You will receive a more comprehensive notice describing tax issues when you are electing your distribution.

Events That May Affect Your Benefit

This section outlines events that may affect your benefit from the Plan.

Military Leave of Absence

Generally, if you return to active employment with a Perdue Company after a period of military service of less than five years, your period of military service will count toward your vesting service, so long as you return to work within the time provided by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Beginning with your return to active work with a Perdue Company, you have a period equal to five years (or, if shorter, three times your period of military service) to make up the contributions you could have made to the Plan during that time. Your compensation for the period of your military service is assumed to be the amount you would have received from the Participating Companies if you had remained an active associate during your period of military service.

If you make up your 401(k) deferrals, your employer will make Company matching contributions equal to the amount you would have received if you worked during your military leave. You are not, however, credited with past investment earnings for those made-up contributions.

Your employer will also make up any Company discretionary contributions you would have received if you had remained an active associate during the period of your military service.

Contributing to Another Tax-Qualified Plan in the Same Year

Your before-tax and Roth contributions (combined) to tax-qualified plans are limited to a dollar amount each calendar year (see “Your Before-Tax 401(k) Deferrals”). Your 401(k) deferrals count toward this annual limit, as well as any before-tax or Roth contributions you make to another employer’s 401(k) plan, Section 408(k) simplified employer pension plan, Section 403(b) annuity contract, or elective employer contributions under Section 408(p)(2)(A)(i) of the Internal Revenue Code.

If you have contributed to another employer’s tax-qualified plan during the same year you make 401(k) deferrals to this Plan, you may need to reduce your 401(k) deferrals so that you do not exceed the limit.

You have until March 1 of the following year to notify your former employer or Principal to request a refund of excess contributions. The excess amount, plus any investment gain or loss, will be issued to you no later than April 15. For more information, call the Principal Contact Center at 1-800-547-7754.

Receiving a Qualified Domestic Relations Order

A Qualified Domestic Relations Order (or “QDRO”) is a court order that provides child support, alimony or marital property rights to a spouse, former spouse or dependent from your Plan account. A QDRO must be issued pursuant to a state domestic relations law and must meet certain technical requirements. A QDRO cannot require the Plan to provide any type or form of payment, or any option, not permitted by the Plan (although it can require payment before you terminate employment).

Under a QDRO, a former spouse may be entitled to the same rights as a current spouse, with respect to some or all of your account. If this is the case, then any provisions in the Plan that require spousal approval, such as naming a nonspouse beneficiary or (if applicable) choosing certain optional forms of payment, may apply to your former spouse with respect to the portion of your account designated for the former spouse (see “Naming Your Beneficiary”).

The Plan Administrator will determine whether an order meets the requirements of a QDRO. While the Plan Administrator is making this determination, you may be prohibited from receiving a distribution from the Plan.

If it appears that you may be subject to a QDRO, you should call the Corporate Benefits Line at 1-800-997-3247. You can obtain, without charge, a copy of the Plan’s QDRO procedures. Your account may be charged a \$600 fee for processing the QDRO, and this fee will be charged before your account is divided and the order is implemented. Information about the fee will be included in the Plan’s QDRO procedures.

If the Plan Fails Non-Discrimination Testing

Federal law requires the Plan to pass certain non-discrimination tests each year. These tests are done to ensure the Plan does not discriminate in favor of highly compensated associates.

If the Plan fails these tests, it may have to refund contributions to some highly compensated associates. If these rules affect you, you will be notified.

If the Plan Becomes Top-Heavy

The Plan is considered “top-heavy” when more than 60% of the Plan assets have been allocated to the accounts of key associates. Generally, key associates are owners, officers, shareholders or highly compensated individuals.

In the unlikely event that the Plan is found to be top-heavy, a minimum allocation of Company contributions of up to 3% of your compensation during a calendar year may be made to your Plan account. This 3% figure may be adjusted in accordance with special rules that may apply in any particular year. You must be employed on the last day of the calendar year in order to receive this “qualified non-elective contribution” (QNEC).

Other consequences may result during years in which the Plan is a top-heavy plan. If the Plan becomes top-heavy, you will be notified.

If the Plan Terminates

If the Plan terminates, your Plan benefit will become fully vested, and the assets of the Plan will be used solely to provide benefits to you, other Plan participants and designated beneficiaries after any expenses of the Plan have been paid. Your benefits will be paid to you as soon as practical. After all assets have been distributed, the Trustee has no more responsibilities under the Plan, and neither you nor your beneficiary will have any further claim to the Plan.

Loss of Benefits

You may lose benefits from the Plan if you terminate employment before earning enough years of vesting service to become 100% vested in your Plan account. You may also lose benefits due to poor investment experience, the application of IRS limits, the imposition of taxes or penalties on your benefits, or the application of a QDRO.

Claims

The Plan Administrator has established these procedures for filing claims for benefits available under the Plan. ***Failure to follow these procedures within the required time periods will result in the loss of your right to sue in court.***

When a claim exists, you, your beneficiary or an authorized representative may call the Principal Contact Center at 1-800-547-7754, or access the Principal website at www.principal.com to start the claims process. The Plan Administrator will respond to the claim in writing within 90 days of the submission, stating whether you are eligible for benefits under the Plan. If the Plan Administrator determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator may extend this response period by up to 90 days and will notify you of the special circumstances and the date by which a decision is expected to be made.

Decisions on Claims

You will receive a decision on your claim in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan Administrator's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination; and
- Demonstrate compliance with the Plan Administrator's processes or safeguards.

Appealing a Claim

The Plan wants to be sure that you and your beneficiaries receive the full benefits for which you are eligible under the Plan.

If an initial claim for benefits under the Plan is denied, in whole or in part, in a letter from a Claims Administrator or otherwise, you have 60 days to appeal the denial. Your appeal must be in writing and should contain the reasons why you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits. Within 60 days after receiving your appeal, the Plan Administrator will give you (and your counsel, if any) an opportunity to present your position to the Plan Administrator in writing, and an opportunity to review any pertinent documents.

The Plan Administrator will notify you of its decision in writing within the 60-day period, stating specifically the basis of the decision and the specific provisions of the Plan on which the decision is based. If because of special circumstances requiring additional time to make a decision the 60-

day period is not sufficient, the decision may be deferred for up to another 60 days at the election of the Plan Administrator, and you will be notified of the delay.

If your claim is denied on appeal, you will receive written notice of the Plan Administrator's final decision on your claim, which contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A statement that you may request, free of charge, reasonable access to and copies of all relevant documents, records and information; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA.

You must exhaust all of the procedures described above before pursuing the claim in any other proceeding.

You cannot file a civil action pursuant to ERISA Section 502(a)(1)(B), with respect to a benefit under the Plan, more than two years after your appeal is denied (or deemed denied).

Any civil action to obtain a benefit under ERISA Section 502(a)(1)(B) must be filed in the United States District Court for the District of Maryland, and the law as stated and applied by the United States Court of Appeals for the Fourth Circuit or the United States District Court for the District of Maryland will govern.

Any claim under ERISA or otherwise with respect to the Plan (other than a claim for benefits under ERISA Section 502(a)(1)(B)) shall be submitted to binding arbitration, on an individual (non-class) basis, within two years after the claim arises (or within such shorter period otherwise applicable to the claim).

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You will receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You will receive a quarterly statement setting forth your Plan account balances and the extent to which you are vested in such account balances.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

Your assets pay investment management fees, which are disclosed in the applicable prospectus for each investment fund. You also pay for routine administrative costs, as well as special fees (such as for processing QDROs). A fee disclosure document will be provided each year.

Funds in the Plan are held in trust for participants and their beneficiaries. The Trustee pays all benefits under the Plan from available assets in the trust. Contributions from participants and Participating Companies go into a trust fund managed under the terms of a trust agreement with the Plan's Trustee.

The Plan Is Not Insured

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), a corporation was established to insure the benefits promised under certain types of pension plans. The corporation is known as the Pension Benefit Guaranty Corporation ("PBGC").

Under present law, the PBGC cannot insure the benefits under this Plan because it is a profit sharing plan in which the benefits you receive are based on your actual account balances. The PBGC insures only "defined benefit pension" plans.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Perdue Companies and any associate. As an "at-will employee," either your employer or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Document Governs

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the plan document that determines your rights and the rights of your dependents under the Plan. In the event of a discrepancy between this summary plan description and the plan document, the plan document will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon any Perdue Company or which alters the Plan or other documents maintained in conjunction with the Plan.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment, to the extent permitted by applicable law.

Assignment of Benefits

Neither you nor your beneficiary may assign your benefits under the Plan. Generally, the Plan and its benefits may not be seized to pay your debts or obligations unless you elect a withdrawal

from your Plan account. However, the Plan is required to honor a QDRO, described in the section “Receiving a Qualified Domestic Relations Order,” which will reduce the Plan benefit payable to you.

Plan May Be Amended or Terminated

The Plan Sponsor expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time, subject to the terms of the plan document. In addition, the Plan Sponsor does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan shall be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Appendix

Table of Current Plan Accounts

401(k) Money Types	Account Description	Loans Available?	In-Service Withdrawal Available?	Hardship Withdrawal Available?
401(k)	Your own <i>before-tax</i> contributions to the Plan	Yes	Age 59½	Yes
Roth 401k	Your own <i>Roth</i> contributions to the Plan	Yes	Age 59½	Yes
Voluntary Unmatched	Your own <i>after-tax</i> contributions that <i>were not</i> eligible for a Company match	Yes	Any age	N/A
Safe Harbor Match	Matching contributions made by the Participating Companies since January 1, 2000	Yes	Age 59½	Yes
Rollover	Before-tax amounts that you may have received from another employer's retirement plan or an IRA, and chose to transfer to this Plan	Yes	Age 59½	Yes
After-tax Rollover	After-tax amounts that you may have received from another employer's retirement plan, and chose to transfer to this Plan	Yes	Any age	N/A
Catch-Up	Your own additional before-tax contributions to the Plan if age 50 or older (over and above the regular limits)	Yes	Age 59½	Yes
Discretionary Contribution	Additional contributions that the Participating Companies may make, once a year, based on its profitability	Yes	Age 59½	No
Qualified Non-Elective Contribution (QNEC)	Corrective contribution	Yes	Age 59½	Yes

Table of Prior Plan Accounts

401(k) Money Types	Account Description	Loans Available?	In-Service Withdrawal Available?	Hardship Withdrawal Available?
Voluntary Matched	Your own after-tax contributions that were eligible for a Company match through December 31, 2009	Yes	Any age	N/A
CNF Plan Rollover	Any rollover contributions that you made to the Coleman Natural Foods, LLC 401(k) Plan, which was merged into this Plan effective January 1, 2013	Yes	Any age	N/A
1% Company Contribution	Company contributions that were made automatically to your account (that is, whether or not you chose to contribute your own money) between October 1, 2003 and December 31, 2008	Yes	Age 59½	No
Company Basic	Company contributions that were made automatically to your account (that is, whether or not you chose to contribute your own money) before July 1, 2000	Yes	65	No
Former MPP	Company contributions that were made to your account in the Perdue Supplemental Retirement Plan (which was combined with the Savings Plan on July 1, 2000), if you were previously a member of that plan	Yes (but requires spouse's consent, if you are married)	No	No
50% Company Match	Matching contributions made by the Participating Companies before January 1, 2000 for members employed at Petersburg, WV; Monterey, TN; or Brentwood, TN	Yes	Age 59½	Yes
Company Match	Matching contributions made by the Participating Companies from 1987 through 1999	Yes	Age 59½	Yes
Company Prior Match	Matching contributions made by the Participating Companies prior to 1987	Yes	Any age	N/A
Employee Prior	Your own after-tax contributions made before 1987	Yes	Any age	N/A

Savings Plan Identification

Plan Name	The official Plan name is The Perdue Savings Plan.
Plan Sponsor	The Plan Sponsor is Perdue Farms Inc.
Type of Administration	The Plan is administered by Principal.
Plan Administrator	The Perdue Farms Inc. Investment Committee 31149 Old Ocean City Road Salisbury, MD 21804 410-543-3000
Trustee	The Plan's Trustee is: Delaware Charter Guarantee & Trust Company d/b/a Principal Trust Company 1013 Centre Road, Suite 300 Wilmington, DE 19805-1265
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator or the Plan Trustee.
Plan Records and Plan Year	The Perdue Savings Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Savings Plan is considered a defined-contribution retirement plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Effective Date	The original effective date of the Plan is December 1, 1955. This SPD is effective as of July 1, 2021.
Plan Number	The Plan Number is 001.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

IRS Annual Dollar Limits

For 2021

Annual Compensation Limit	\$290,000
Annual Contribution Limit	\$58,000
Annual Deferral Limit	\$19,500
Annual Catch-Up Deferral Limit	\$6,500
Highly Compensated Employee	\$130,000 paid in 2020
Adjusted Gross Income Limits For Tax Credits	\$66,000 for married filing jointly \$49,500 for head of household \$33,000 for single or married filing separately

Matching Contribution Examples

If you are eligible for the match from the first day of the Plan Year:

Example: Ms. Jones has satisfied the year of service requirement and is eligible for matching contributions as of January 1, 2021. Her eligible compensation is \$2,500 per bi-weekly pay period. For each of the first four pay periods in 2021, she contributes before-tax 4% of eligible compensation (\$100 per pay, \$400 total), and receives total matching contributions of \$400. For the fifth pay period in 2021, she contributes before-tax 12% of eligible compensation (\$300). Her matching contribution for the fifth pay period is \$225, which is calculated as follows:

Total before-tax contributions for 2021 (year-to-date, including the fifth pay period): \$700

Total eligible compensation for 2021 (year-to-date, including the fifth pay period): \$12,500

5% of total eligible compensation for 2021 (year-to-date, including the fifth pay period): \$625

Match for the fifth pay period: \$225, which is \$625 (the lesser of year-to-date before-tax contributions or 5% of year-to-date eligible compensation), minus the \$400 of match already received for 2021

If you become eligible for the match during the Plan Year:

Example: Ms. Smith receives eligible compensation of \$12,000 for each of the 26 bi-weekly pay periods during 2021. She satisfies the year of service requirement and becomes eligible for matching contributions as of the sixth payroll period in 2021. She is under age 50 and not eligible for catch-up contributions, so her annual before-tax contribution limit for 2021 is \$19,500.

For the first five payroll periods in 2021, she has contributed before-tax 12% of her pay (\$1,440 per pay, or \$7,200), and receives no matching contributions because she is not yet eligible. After becoming eligible (beginning with the sixth pay period in 2021), she continues to contribute at a rate of 12% (\$1,440 per pay), and receives matching contributions of \$600 per pay. She reaches the IRS limit on before-tax contributions (\$19,500 for 2021) on the 14th pay period, and can no longer make before-tax contributions for 2021. At that point, she has received matching contributions of \$5,400 (she has been matched for nine pay periods), and cannot receive further matching contributions in 2021 because she can no longer contribute.

Ms. Smith could have maximized her 2021 matching contributions by taking the following steps:

1. Calculating the maximum available match for 2021, by multiplying the 5% match rate by her eligible compensation payable on or after she becomes eligible for the match ($5\% \times \$252,000$ (which is \$12,000 for 21 pay periods)), yielding a maximum available 2021 match of \$12,600. (Had her compensation payable after

she becomes eligible for the match exceeded the 2021 IRS limit of \$290,000, her maximum 2021 match would have been \$14,500.)

2. Ensuring that she is able to contribute at least \$12,600 for 2021 after she becomes eligible for the match, by limiting her 2021 before-tax contributions before she is eligible for the match to \$6,900 (i.e., \$19,500 – \$12,600).

3. Setting her before-tax contribution rate, following her match eligibility date, at a rate that will enable her to contribute for all of the remaining pay periods in 2021, and not reach the maximum before the end of 2021. A 5% before-tax election will yield this result (i.e., \$12,600 divided by 21 payroll periods will allow her to contribute \$600 for each of the 21 payroll periods, and receive the maximum available \$600 match each pay period).

In each of the above examples, any portion of the participant's before-tax contributions could be substituted with Roth contributions.

THE PERDUE SAVINGS PLAN SUMMARY PLAN DESCRIPTION

For associates covered by collective bargaining agreements with:

- **Golden State United Food and Commercial Workers Union, Local No. 8, Petaluma, CA**
- **International Association of Machinists and Aerospace Workers, Local No. 1596, Petaluma, CA**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de ahorros de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-547-7754 para obtener ayuda.

Revised July 1, 2021

Preface

This is a Summary Plan Description (SPD) of the benefits available under The Perdue Savings Plan (“the Plan”) to associates entitled to Plan participation under the terms of collective bargaining agreements with the following locals:

- Golden State United Food and Commercial Workers Union, Local No. 8, Petaluma, CA (“Local 8”)
- International Association of Machinists and Aerospace Workers, Local No. 1596 Petaluma, CA (“Petaluma Machinists”)

The SPD summarizes the benefits available under the terms of the Plan that are in effect as of July 1, 2021. It explains in non-technical language how the Plan works, and it replaces all prior SPDs for the Plan.

Contribution Types

There are a number of contribution types made under the Plan. The Appendix at the end of this SPD has a full list of contribution-type subaccounts maintained under the Plan. Not all sections of the SPD apply to each contribution type. For any questions, please call the Principal Contact Center at 1-800-547-7754.

IRS Annual Dollar Limits

There are a number of IRS annual dollar limits that apply to the Plan. Each year, these limits may change based on inflation. For updated annual dollar limits, please see the Appendix at the end of this SPD.

More detailed information is provided in the plan document, a copy of which is available upon request. If there is a difference between how the SPD and the plan document describe the eligibility rules and the benefits being provided under the Plan, the plan document will control and govern the operation of the Plan.

In this SPD, Perdue Farms Inc. is referred to as the “Plan Sponsor,” each of Perdue’s related companies is referred to as a “Perdue Company,” and each Perdue Company that has adopted the Plan to allow its eligible associates to participate is referred to as a “Participating Company.”

The Plan Sponsor has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and your collective bargaining agreement).

If you have questions regarding your benefits, call the Principal Contact Center at 1-800-547-7754. Participation in the Plan is neither an offer nor a guarantee of future employment.

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Introduction

The Plan enables you to save money for retirement while taking advantage of current tax laws, once you meet the eligibility requirements. Not only do your earnings grow on a tax-deferred basis (you don't pay taxes on your earnings until you withdraw them from your Plan account), you can reduce your current income taxes just by contributing to the Plan. And, when you make before-tax contributions to your account in the Plan, your employer matches a portion of those contributions.

Although the money in your account is meant to fund your retirement, you may be able to access some of the funds before termination of employment through loans or withdrawals (when you have a severe financial hardship or reach age 59½, or otherwise).

Eligibility and Enrollment

This section outlines the Plan's rules of eligibility for associates to participate.

Eligible Associates

You are eligible to participate in the Plan if you are an eligible associate of a Participating Company entitled to Plan participation under the terms of the collective bargaining agreement with Local 8 or Petaluma Machinists.

Get the Most from the Plan

If you are an eligible associate, you must contact Principal by calling 1-800-547-7754 to enroll in the Plan or enroll online at www.principal.com. To use the Plan to your best advantage, you must contribute to the Plan regularly. Read on to learn how.

When You May Contribute and Receive Company Matching Contributions

In order to begin saving for your future by contributing to your Plan account and receiving Company matching contributions, you must also:

- Be at least 21 years old; and
- Have completed at least six months of service (no specific hours of service required).

You become eligible on the first day of the month after (or upon which) you meet the above requirements.

To receive Company matching contributions, you must make 401(k) deferrals (before-tax contributions) to the Plan.

Naming Your Beneficiary

A beneficiary is the person who receives the money in your account if you die. You should name a primary beneficiary to ensure that your benefits are distributed according to your wishes. It is also important to name a contingent beneficiary who will receive your benefits if your beneficiary dies before you.

You may designate (or change) your primary beneficiary and/or contingent beneficiary online by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

If you are married and at any time you want to name someone other than or in addition to your spouse as your primary beneficiary, your spouse must give consent, witnessed by a notary. This is required by federal law.

If you are not married and you do not name a beneficiary, no valid designation of beneficiary exists, or your beneficiaries are no longer living, the Plan will pay your account balance to your estate.

Contributions to the Plan

The Plan and IRS rules govern both the type and amount of contributions that you and your employer may make to the Plan.

Your Compensation

Both you and your employer contribute to the Plan to build your benefit. The amount you contribute is a percentage of your “compensation.” Your compensation is your pay from a Participating Company reportable on Form W-2, Box 1, plus the before-tax contributions you make toward employer benefit programs. But your compensation does not include amounts you receive from a Participating Company as fringe benefits, taxable welfare benefits, expense allowances or severance pay.

In addition, the IRS limits your compensation for purposes of Company contributions to the Plan. This means that your Company matching contributions for a year will not exceed the annual compensation limit multiplied by the matching contribution rate. See the Appendix for the annual compensation limit.

The IRS annual compensation limit does not impact your ability to make before-tax or after-tax contributions (which are subject to the other limits described in this SPD).

Annual Contribution Limits

The IRS also limits the amount that **you and your employer** may contribute to the Plan in a calendar year. This limit is the lesser of:

- 100% of your compensation; or
- An annual dollar limit. This annual dollar limit applies to contributions to all of the Perdue Company tax-qualified plans in which you participate during a calendar year; see “Contributing to Another Tax-Qualified Plan in the Same Year.” See the Appendix for the annual contribution limit.

Please note: Rollover contributions (described below) do not apply to these annual limits.

Your Contributions to the Plan

When you are eligible to contribute to the Plan (see “When You May Contribute”), you may contribute a percentage of your compensation to the Plan from each Participating Company paycheck. You may contribute as little as 1% or as much as 100% of your compensation (less other deductions), in whole percentages, as 401(k) deferrals and/or after-tax contributions. You may change the amount you contribute at any time.

Your 401(k) Deferrals (Before-Tax Contributions)

Your 401(k) deferrals come from your pay before federal (and most state and local) income taxes are figured. Unlike your before-tax contributions to other employer benefit plans, your 401(k) deferrals *are* subject to Social Security and Medicare taxes (FICA withholding).

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as a 401(k) deferral. See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals only (not your after-tax contributions).

Your After-Tax Contributions

Your after-tax contributions are deducted from your pay after taxes are figured.

If you are a “highly compensated employee” as defined by IRS rules, your after-tax contributions may be limited in order for the Plan to meet non-discrimination tests. You are a highly compensated employee if your compensation from Perdue Companies for the prior year exceeded the threshold amount specified by the IRS for the year. See the Appendix for the highly compensated employee threshold amount. If the Plan fails a non-discrimination test and your after-tax contributions must be limited, you will be notified.

Note: After-tax contributions are not matched by your employer.

Your Rollover Contributions

You may make a rollover contribution to the Plan at any time. Rollover contributions are transfers of money from another tax-qualified plan – such as a former employer’s 401(k) plan or an individual retirement account – to this Plan. Rollover contributions must be transferred from your former plan or provided by you within 60 days after you receive the distributions from your former plan. You may make a rollover contribution of pre-tax or after-tax funds (but not Roth funds) from a former employer’s plan, and you may make a rollover contribution of pre-tax funds (but not after-tax funds or Roth funds) from an individual retirement account. If you wish to make a rollover contribution of after-tax funds from a former employer’s plan, the funds must be transferred directly from your former employer’s plan.

Amounts you transfer to the Plan as a rollover contribution do not count against any Plan or IRS contribution limit, and they are not matched by any Company contribution.

The tax laws and rules involving rollovers are complex. Whether you can, or even should, roll over an amount you previously received is a question you should discuss with your personal tax advisor, because each person’s circumstances differ.

For more information or to make a rollover to the Plan, call the Principal Contact Center at 1-800-547-7754.

Note: Rollover contributions are not matched by your employer.

Example: Ms. Jones is eligible to participate in the Plan. Ms. Jones has a personal individual retirement account (IRA) with a balance of \$50,000 of pre-tax funds. In addition to making 401(k) deferrals and receiving matching contributions, she may have her IRA custodian transfer the \$50,000 to her Plan account, as a rollover contribution. The transferred funds (as adjusted for earnings and losses) will be separately accounted for as a subaccount within her Plan account. Her rollover contribution will not affect the amount she is otherwise eligible to contribute as 401(k) deferrals and will not be matched.

Your Catch-Up Contributions

During any calendar year in which you are age 50 or older, you may make catch-up contributions to the Plan. These are before-tax contributions, but they do not count toward the IRS dollar limit that generally applies to your 401(k) deferrals or the IRS overall annual contribution limit (100% of your pay, or the annual contribution limit for the year).

The IRS has a dollar limit for catch-up contributions. Therefore, if you are age 50 or older, you may contribute up to the combined amount of the annual deferral limit and the annual catch-up deferral limit. The IRS allows catch-up contributions to allow people to save more for retirement in their later working years.

See the Appendix for each of the limits discussed in this section.

Note: Catch-up contributions are not matched by your employer.

Tax Credit for Your Contributions

You may be entitled to a tax credit for your contributions to the Plan, in addition to the tax savings from these before-tax contributions. The federal tax credit is available only if your “adjusted gross income” for tax purposes is below certain limits, which are set forth in the Appendix.

This tax credit ranges from 10% to 50% of the first \$2,000 (\$4,000 if married filing jointly) you contribute to the Plan (either before-tax or after-tax) for the calendar year, depending on how you file your tax return. You must meet certain conditions to qualify for this tax credit; please consult your tax advisor.

Company Matching Contributions

When you make before-tax contributions to the Plan, your employer makes matching contributions to your Plan account. Your employer provides a match each pay period based on the following formula:

- 100% of your before-tax contributions per pay period, for your before-tax contributions of up to 3% of your eligible pay for the pay period; plus
- 50% of your before-tax contributions per pay period, for your before-tax contributions of the next 2% of your eligible pay for the pay period.

There are no “true-up” matching contributions, so you may wish to contribute at a level pace throughout the year, and avoid frontloading your before-tax contributions. If you reach the IRS limit on before-tax contributions before the end of the year, you will be unable to receive the full available match. The match is not intended to qualify for “safe harbor” status under IRS nondiscrimination rules.

As explained above in the section entitled “Your Compensation,” your annual match cannot exceed the amount determined by applying the match formula to the IRS annual compensation limit (set forth in the Appendix).

Managing Your Plan Account

The Plan's Trustee, Principal Trust Company, holds in trust all the assets of the Plan. When you become an eligible associate, Principal sets up a separate account in the Plan for you. Your Plan account is used to hold your Plan benefit.

Investing Your Plan Account

As a participant, you are responsible for directing the manner in which the funds are invested. Because the Plan is a "tax-qualified plan" under IRS rules, you defer paying taxes on the investment earnings while they remain in your Plan account.

You may invest your Plan account among a menu of investment funds. You can place 100% of those amounts in one fund or spread your investment in multiples of 1% among all the funds – just make sure your total investments add up to 100%.

You may change your investment decisions at any time. You also may make separate investment elections for your current account balance and for your future contributions to the Plan. Any changes you make become effective as soon as administratively feasible. Make your investment elections online at www.principal.com, or by calling the Principal Contact Center at 1-800-547-7754. Expenses of administering the Plan and trust may be paid from the trust fund. Fees and costs associated with the investment of your account may be charged to your Plan account.

Short-Term Trading Is Prohibited

The Plan is designed for retirement savings, not for short-term investments. The Plan Administrator and Trustee monitor investment changes and have the right to place restrictions on participants whose trading patterns appear to be short-term only and not in keeping with the Plan's intent.

In addition, some investment funds may have certain restrictions or charge a "short-term trading redemption fee" when money is transferred from a fund shortly after being deposited. Please see the prospectus of the investment funds you choose to understand any restrictions or fees related to short-term trading.

Information about the investment funds is available on the Principal website at www.principal.com.

The "Default" Investment Fund

If you do not choose how to invest your account, your account will be automatically invested in a qualified default investment fund that meets the requirements outlined in the Department of Labor's regulations. If you remain in the default investment fund, you may transfer out of this investment to another Plan investment fund at a later time.

How to Make Your Investment Choices

By phone: Call the Principal Contact Center at 1-800-547-7754.

Online: Use the secure Principal website at www.principal.com.

Choosing Investment Funds Is Your Responsibility

The Plan is intended to comply with Section 404(c) of the Employee Retirement Income Security Act (ERISA) and the Department of Labor's final regulation on "qualified default investment

alternatives” (QDIAs). This means you are legally responsible for your investment choices. Because the Plan complies with this section of ERISA, the fiduciaries of the Plan, including the Plan Sponsor, the Trustee, and the Plan Administrator, will be relieved of any legal liability for any losses that are the direct and necessary result of the investment directions that you give.

When you direct the investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your Plan account does not share in the investment performance of other participants who have directed their own investments.

Your Plan account will be updated for investment earnings or losses each day that the applicable investment markets are open.

The Plan Administrator has established participant direction procedures setting forth investment choices available to you, the frequency with which you can change your investment choices, and instructions on how you can obtain other important information on directed investments. These procedures are provided to you when you enroll in the Plan. It is important that you carefully follow the election procedures in order to ensure that your elections are properly indicated. If you have questions about these procedures, contact the Principal Contact Center at 1-800-547-7754 or by logging onto www.principal.com.

You are not required to direct investments. If you choose not to direct investments, then your account will be invested in the “default” investment fund (as described above).

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. There are no guarantees of performance. The Plan Sponsor, the Plan Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

You can check your account balance, make investment elections or changes or request information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

A personal identification number (“PIN”) is assigned to each Plan participant. This PIN and your Social Security Number will allow you to access your account via the secure website (www.principal.com). You also can reach an account representative by phone at 1-800-547-7754.

Receiving Plan Investment Information

To comply with Section 404(c) of ERISA and the 404(c) Regulations, the Plan names the Plan Administrator – the Perdue Farms Inc. Investment Committee – as the fiduciary (“404(c) Fiduciary”) responsible for providing Plan investment information upon request of you or your beneficiary. You may obtain information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

In addition to the material you receive from the Plan, you have the right to request additional information (available at no cost) to help you decide which investment options to select. The information you may request includes:

- A description of the annual operating expenses of each investment alternative (for example, investment management fees, administrative fees) which reduce your rate of

return, and the aggregate amount of expenses expressed as a percentage of average net assets of the investment alternative.

- Copies of any prospectuses, financial statements and reports, and any other materials relating to the investment alternatives, to the extent this information is provided to the Plan.
- With respect to each investment alternative, a list of assets that make up the portfolio, the value of each asset (or the proportion of the investment alternative to which it belongs); and with respect to each asset which is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term and the rate of return on the contract.
- Information concerning the value of shares or units in the investment alternatives, and information about the past and current investment performance, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment alternative held in your Plan account.

Vesting in Your Plan Account

“Vesting” means your right to receive the value of your Plan account. You are always 100% vested in your entire Plan account, which means that your Plan account may not be forfeited or taken from you. But please note that the value of your Plan account may go up or down, based on the value of the Plan’s investment funds you have chosen.

Receiving Money from the Plan While You Are Working

The purpose of the Plan is to help you save money for retirement years, but it includes features that allow you to receive money from your Plan account while you are still working for the Perdue Companies.

Plan Loans

You may borrow from your Plan account and use the money for any purpose. The Plan has a written loan policy that explains the rules governing Plan loans in detail; for a copy, call the Principal Contact Center at 1-800-547-7754.

Your Plan loan cannot be more than the lesser of:

- One-half of your Plan account at the time of the loan; and
- \$50,000, *minus* your highest outstanding Plan loan balance during the past 12 months.

The minimum loan allowed by the Plan is \$1,000. You may have only one Plan loan at a time. No more than two loan applications may be approved during any calendar year and a minimum of one month must pass between the dates that one loan is paid off and a new loan is applied for. A \$75 loan processing fee is charged for each loan from the Plan.

All Plan loans must be repaid within five years, with interest. You repay your loans by payroll deduction, but you may repay your loan in full, without penalty, with a cashier's check or money order made payable to Principal Trust Company, the Trustee.

Non-Hardship Withdrawals

You may withdraw certain funds from your Plan account if you meet the requirements set out by the Plan and/or the IRS. All or a portion of any withdrawal from your Plan account is taxable to you; see "Taxes on Your Plan Benefits" for details.

The table in the Appendix of this SPD includes short descriptions of the accounts and the distribution options available for each account. For more information on which types of accounts, if any, may be eligible for a non-hardship withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Age 59½ or Older

When you are age 59½ or older, you may withdraw money from these funds in your Plan account at any time, without proving a financial hardship:

- Your 401(k) deferrals;
- Your rollover contributions; and
- Company matching contributions.

Taxes are withheld from your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

The table in the Appendix of this SPD includes short descriptions of the accounts and the distribution options available for each account. For more information on which types of accounts, if any, may be eligible for an age 59½ (or older) withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Younger than Age 59½

If you are not yet age 59½ and you do not have a financial hardship, you may withdraw only the following funds in your Plan account:

- After-tax **matched** contributions you made to the Plan more than two years ago;
- After-tax **unmatched** contributions you made to the Plan; and
- After-tax rollover contributions you rolled over to this Plan.

Taxes are withheld from the taxable portion of your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

Hardship Withdrawals

You may make a hardship withdrawal of certain funds in your Plan account if you meet the requirements set out by the Plan and/or the IRS. Hardship withdrawals are allowed only when you need to pay:

- Medical expenses not covered by insurance, for you or your dependents;
- Costs directly related to the purchase of your home – but not for regular mortgage payments;
- College tuition, fees, and room and board expenses for you or your dependent for the next 12 months;
- Expenses to prevent your eviction or foreclosure on your home;
- Funeral or burial expenses for your parent, spouse or dependent;
- Expenses to repair uninsured damage to your home resulting from a natural disaster; or
- Expenses and losses (including loss of income) you incur due to a disaster declared by FEMA, if your principal residence or place of employment is located in an area designated by FEMA for individual assistance.

To qualify for a hardship withdrawal, you must show that you have first exhausted all other sources of funds to meet your need, including distributions (but not loans) from the Plan. You may withdraw only the amount needed to meet your financial need, including amounts you must pay in taxes and penalties on your withdrawal. The Plan Administrator requires documentation from a third party to justify your financial need.

Taxes are not required to be withheld from your hardship withdrawal, and it is not eligible for tax-deferred rollover.

See the table in the Appendix of this SPD for details about the contribution types that are eligible for a hardship withdrawal, or call the Principal Contact Center at 1-800-547-7754.

Receiving Your Benefit from the Plan

Because the Plan is designed to help fund your retirement, the Plan's benefits are payable when you reach age 65, the Plan's normal retirement age. But you may receive your benefit from the Plan before or after that date, depending on your personal circumstances.

The Plan pays benefits in a single lump sum, or you may take partial distributions of your account (subject to the Plan's administrative procedures).

To file a claim for benefits from the Plan, contact the Principal Contact Center at 1-800-547-7754. See the section "Claims" for more information.

When You Retire or Become Disabled

You may receive your Plan benefit when you retire at age 65 or older, or when you become totally and permanently disabled under the terms of a Perdue Company disability plan or Social Security.

When Your Employment Ends

If your employment ends before you reach age 65, you may receive your Plan benefit. When your employment ends, Principal sends you information about how to receive your Plan benefit. You will have the option of rolling over your Plan benefit to another tax-qualified plan, as described in "Rolling Over Your Benefit to Another Plan."

The value of your Plan account determines your options for receiving your Plan benefit.

Options for Deferring Your Benefit

If your employment ends and you wish to defer receiving your Plan benefit, you may do so until you reach your "required beginning date" (see below). Call the Principal Contact Center at 1-800-547-7754 for more information about the "required minimum distribution" rules.

When Your Plan Account Is More Than \$5,000

If the value of your Plan account (excluding any rollover contributions into the Plan) is more than \$5,000 when your employment ends, you may receive your Plan benefit at any time, but generally not later than your "required beginning date" which is the April 1st of the year following the later of the year in which you attain age 72 (age 70½ if you reached such age by December 31, 2019), or the year in which you terminate employment. At that time, you may take a lump sum distribution, or partial distributions, as long as they are sufficient to meet the "required minimum distribution" rules. You continue to direct the investment of your Plan account, using the same investment options offered to all other Plan participants.

When Your Plan Account Is Between \$1,000 and \$5,000

If your Plan account is more than \$1,000, but not more than \$5,000 (excluding any rollover contributions into the Plan), when your employment ends, you must receive your benefit from the Plan. Principal will send you information about your options for receiving your benefit from the Plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If you do not tell Principal how you want to receive your Plan benefit, your Plan benefit will be rolled over to an individual retirement account (IRA). The Plan Administrator has chosen the Total IRA program, offered by The Mid Atlantic Trust Company, as the automatic IRA to receive your rollover. Your rollover funds will be invested in a type of investment designed to preserve principal and provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund), unless you elect other investments.

All fees and expenses related to this rollover IRA and the IRA investments will be allocated solely to you, as the IRA holder. You may transfer the IRA to another IRA of your choosing.

For more information regarding the Plan's automatic rollover provisions, the IRA provider and fees and expenses attendant to the IRA, call the Principal Contact Center at 1-800-547-7754.

When Your Plan Account Is \$1,000 or Less

If your Plan account is \$1,000 or less when your employment ends, you must receive your benefit from the Plan. Principal will notify you of your right to roll over your Plan benefit to a rollover IRA or another tax-qualified plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If You Die

If you have a balance in your Plan account when you die, the Plan will pay it to your beneficiary (described in "Naming Your Beneficiary"). Your beneficiary may make periodic withdrawals, or defer receiving your Plan benefit, but no longer than shown here (if you die after December 31, 2019):

- **When your beneficiary is your spouse**, he or she may defer receiving your Plan benefit until the *later of*:
 - The end of the first complete calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules;
 - The end of the calendar year in which you would have reached age 72 (your "required distribution date"), with annual distributions in amounts that satisfy the required minimum distribution rules; or
 - The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is an "eligible designated beneficiary" other than your spouse**, the Plan benefit must begin by the later of:
 - December 31 of the calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules; or

- The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is not an “eligible designated beneficiary”**, the Plan benefit must be distributed by the end of the tenth calendar year following the calendar year of your death.
- **An “eligible designated beneficiary”** is your surviving spouse, your child who has not reached the age of majority at your death, a chronically ill individual (as defined by the Internal Revenue Code), or any other individual who is not more than ten years younger than you.

Rolling Over Your Benefit to Another Plan

If your employment ends and you take a distribution of your Plan account, you have the option to roll over your Plan benefit to another tax-qualified plan, such as a Rollover IRA or another employer’s tax-qualified plan, such as a 401(k), 403(b), or a governmental 457(b) plan.

There are two ways to make a rollover from the Plan:

Indirect Rollover

When you receive a distribution from the Plan, you have 60 days to roll over that distribution to another tax-qualified plan. If you wait more than 60 days to complete your rollover, the full value of your distribution from the Plan becomes taxable to you.

The Plan is required to withhold 20% of the distribution of your Plan benefit for federal income taxes. (Additional state-level mandatory tax withholding may also apply.) In order to defer taxes on the full value of your Plan benefit, you must roll over 100% of your Plan benefit within the 60-day limit. This means you will have to use other funds with your rollover contribution to make up the 20% withheld for taxes, otherwise the 20% withheld will become taxable to you.

Direct Rollover

You may avoid tax withholding by electing a direct rollover of your account to another tax-qualified plan or account. With a direct rollover, your funds are transferred directly to the new plan or account, and you do not take possession of them.

Taxes on Your Plan Benefits

The Plan is a “tax-qualified plan” under IRS regulations. This means that all of the money in your Plan account (other than after-tax contributions)—including Company contributions and investment earnings—is sheltered from income taxes until you take it from the Plan (and is further sheltered if you do a direct rollover as discussed above). This section describes how taxes affect your benefits when you receive them from the Plan, according to tax laws in effect at the time this SPD was written.

Ordinary Income Taxes

Before-tax deferral contributions, Company contributions, and their investment earnings are subject to federal, state and local income taxes upon distribution. After-tax contributions are tax-free upon distribution, but their investment earnings are taxable upon distribution. Taxation may be deferred through a rollover to another employer-sponsored retirement plan or an individual retirement account.

For distributions that are not directly rolled over, the Plan is required to withhold 20% of the taxable amount as federal income tax withholding. Additional state and local mandatory withholding may also apply.

Tax treatment and rollover rules are complex, vary based on contribution type and the type of account receiving the rollover, and are subject to change. You will receive additional information when you are ready to take a distribution, and should consult with a tax advisor for assistance.

Additional 10% Tax

If you receive a distribution from the Plan before you reach age 59½ – as a Plan benefit or as a hardship withdrawal – that distribution may be subject to an additional 10% federal tax for an “early distribution,” sometimes referred to as a “penalty tax.” This additional 10% tax does not apply, however, if your distribution is:

- Paid due to your disability;
- Paid as a series of equal payments over your life or life expectancy (or your and your beneficiary's lives or life expectancies);
- Used to pay certain tax-deductible medical expenses;
- Paid directly to the government to satisfy a federal tax levy;
- Paid to you during a period of at least 180 days of active military duty; or
- Paid to an “alternate payee” under a Qualified Domestic Relations Order (see “Receiving a Qualified Domestic Relations Order”).

More information about the additional 10% federal tax is found on IRS Form 5329.

You will receive a more comprehensive notice describing tax issues when you are electing your distribution.

Events That May Affect Your Benefit

This section outlines events that may affect your benefit from the Plan.

Military Leave of Absence

Generally, if you return to active employment with a Perdue Company after a period of military service of less than five years, your period of military service will count toward your vesting service, so long as you return to work within the time provided by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Beginning with your return to active work with a Perdue Company, you have a period equal to five years (or, if shorter, three times your period of military service) to make up the contributions you could have made to the Plan during that time. Your compensation for the period of your military service is assumed to be the amount you would have received from the Participating Companies if you had remained an active associate during your period of military service.

If you make up your 401(k) deferrals, your employer will make Company matching contributions equal to the amount you would have received if you worked during your military leave. You are not, however, credited with past investment earnings for those made-up contributions.

Contributing to Another Tax-Qualified Plan in the Same Year

Your before-tax contributions to tax-qualified plans are limited to a dollar amount each calendar year (see “Your Before-Tax 401(k) Deferrals”). Your 401(k) deferrals count toward this annual limit, as well as any before-tax contributions you make to another employer’s 401(k) plan, Section 408(k) simplified employer pension plan, Section 403(b) annuity contract, or elective employer contributions under Section 408(p)(2)(A)(i) of the Internal Revenue Code.

If you have contributed to another employer’s tax-qualified plan during the same year you make 401(k) deferrals to this Plan, you may need to reduce your 401(k) deferrals so that you do not exceed the limit.

You have until March 1 of the following year to notify your former employer or Principal to request a refund of excess contributions. The excess amount, plus any investment gain or loss, will be issued to you no later than April 15. For more information, call the Principal Contact Center at 1-800-547-7754.

Receiving a Qualified Domestic Relations Order

A Qualified Domestic Relations Order (or “QDRO”) is a court order that provides child support, alimony or marital property rights to a spouse, former spouse or dependent from your Plan account. A QDRO must be issued pursuant to a state domestic relations law and must meet certain technical requirements. A QDRO cannot require the Plan to provide any type or form of payment, or any option, not permitted by the Plan (although it can require payment before you terminate employment).

Under a QDRO, a former spouse may be entitled to the same rights as a current spouse, with respect to some or all of your account. If this is the case, then any provisions in the Plan that require spousal approval, such as naming a nonspouse beneficiary or (if applicable) choosing certain optional forms of payment, may apply to your former spouse with respect to the portion of your account designated for the former spouse (see “Naming Your Beneficiary”).

The Plan Administrator will determine whether an order meets the requirements of a QDRO. While the Plan Administrator is making this determination, you may be prohibited from receiving a distribution from the Plan.

If it appears that you may be subject to a QDRO, you should call the Corporate Benefits Line at 1-800-997-3247. You can obtain, without charge, a copy of the Plan's QDRO procedures. Your account may be charged a \$600 fee for processing the QDRO, and this fee will be charged before your account is divided and the order is implemented. Information about the fee will be included in the Plan's QDRO procedures.

If the Plan Fails Non-Discrimination Testing

Federal law requires the Plan to pass certain non-discrimination tests each year. These tests are done to ensure the Plan does not discriminate in favor of highly compensated associates.

If the Plan fails these tests, it may have to refund contributions to some highly compensated associates. If these rules affect you, you will be notified.

If the Plan Terminates

If the Plan terminates, your Plan benefit will remain fully vested, and the assets of the Plan will be used solely to provide benefits to you, other Plan participants and designated beneficiaries after any expenses of the Plan have been paid. Your benefits will be paid to you as soon as practical. After all assets have been distributed, the Trustee has no more responsibilities under the Plan, and neither you nor your beneficiary will have any further claim to the Plan.

Loss of Benefits

You may lose benefits from the Plan due to poor investment experience, the application of IRS limits, the imposition of taxes or penalties on your benefits, or the application of a QDRO.

Claims

The Plan Administrator has established these procedures for filing claims for benefits available under the Plan. ***Failure to follow these procedures within the required time periods will result in the loss of your right to sue in court.***

When a claim exists, you, your beneficiary or an authorized representative may call the Principal Contact Center at 1-800-547-7754, or access the Principal website at www.principal.com to start the claims process. The Plan Administrator will respond to the claim in writing within 90 days of the submission, stating whether you are eligible for benefits under the Plan. If the Plan Administrator determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator may extend this response period by up to 90 days and will notify you of the special circumstances and the date by which a decision is expected to be made.

Decisions on Claims

You will receive a decision on your claim in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan Administrator's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination; and
- Demonstrate compliance with the Plan Administrator's processes or safeguards.

Appealing a Claim

The Plan wants to be sure that you and your beneficiaries receive the full benefits for which you are eligible under the Plan.

If an initial claim for benefits under the Plan is denied, in whole or in part, in a letter from a Claims Administrator or otherwise, you have 60 days to appeal the denial. Your appeal must be in writing and should contain the reasons why you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits. Within 60 days after receiving your appeal, the Plan Administrator will give you (and your counsel, if any) an opportunity to present your position to the Plan Administrator in writing, and an opportunity to review any pertinent documents.

The Plan Administrator will notify you of its decision in writing within the 60-day period, stating specifically the basis of the decision and the specific provisions of the Plan on which the decision

is based. If because of special circumstances requiring additional time to make a decision the 60-day period is not sufficient, the decision may be deferred for up to another 60 days at the election of the Plan Administrator, and you will be notified of the delay.

If your claim is denied on appeal, you will receive written notice of the Plan Administrator's final decision on your claim, which contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A statement that you may request, free of charge, reasonable access to and copies of all relevant documents, records and information; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA.

You must exhaust all of the procedures described above before pursuing the claim in any other proceeding.

You cannot file a civil action pursuant to ERISA Section 502(a)(1)(B), with respect to a benefit under the Plan, more than two years after your appeal is denied (or deemed denied).

Any civil action to obtain a benefit under ERISA Section 502(a)(1)(B) must be filed in the United States District Court for the District of Maryland, and the law as stated and applied by the United States Court of Appeals for the Fourth Circuit or the United States District Court for the District of Maryland will govern.

Any claim under ERISA or otherwise with respect to the Plan (other than a claim for benefits under ERISA Section 502(a)(1)(B)) shall be submitted to binding arbitration, on an individual (non-class) basis, within two years after the claim arises (or within such shorter period otherwise applicable to the claim).

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You will receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You will receive a quarterly statement setting forth your Plan account balances.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

Your assets pay investment management fees, which are disclosed in the applicable prospectus for each investment fund. You also pay for routine administrative costs, as well as special fees (such as for processing QDROs). A fee disclosure document will be provided each year.

Funds in the Plan are held in trust for participants and their beneficiaries. The Trustee pays all benefits under the Plan from available assets in the trust. Contributions from participants and Participating Companies go into a trust fund managed under the terms of a trust agreement with the Plan's Trustee.

The Plan Is Not Insured

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), a corporation was established to insure the benefits promised under certain types of pension plans. The corporation is known as the Pension Benefit Guaranty Corporation ("PBGC").

Under present law, the PBGC cannot insure the benefits under this Plan because it is a profit sharing plan in which the benefits you receive are based on your actual account balances. The PBGC insures only "defined benefit pension" plans.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Perdue Companies and any associate. As an "at-will employee," either your employer or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Document Governs

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the plan document that determines your rights and the rights of your dependents under the Plan. In the event of a discrepancy between this summary plan description and the plan document, the plan document will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon any Perdue Company or which alters the Plan or other documents maintained in conjunction with the Plan.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment, to the extent permitted by applicable law.

Assignment of Benefits

Neither you nor your beneficiary may assign your benefits under the Plan. Generally, the Plan and its benefits may not be seized to pay your debts or obligations unless you elect a withdrawal

from your Plan account. However, the Plan is required to honor a QDRO, described in the section “Receiving a Qualified Domestic Relations Order,” which will reduce the Plan benefit payable to you.

Plan May Be Amended or Terminated

The Plan Sponsor expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time, subject to the terms of the plan document. In addition, the Plan Sponsor does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan shall be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Appendix

Table of Plan Accounts

401(k) Money Types	Account Description	Loans Available?	In-Service Withdrawal Available?	Hardship Withdrawal Available?
401(k)	Your own <i>before-tax</i> contributions to the Plan	Yes	Age 59½	Yes
Voluntary Unmatched	Your own <i>after-tax</i> contributions that <i>were not</i> eligible for a Company match	Yes	Age 59½	N/A
Match	Matching contributions made by the Participating Companies	Yes	Age 59½	Yes
Rollover	Before-tax amounts that you may have received from another employer's retirement plan or an IRA, and chose to transfer to this Plan	Yes	Age 59½ (Local 8 participants may withdraw pre-2013 rollover amounts at any time)	Yes
After-tax Rollover	After-tax amounts that you may have received from another employer's retirement plan, and chose to transfer to this Plan	Yes	Any age	N/A
Catch-Up	Your own additional before-tax contributions to the Plan if age 50 or older (over and above the regular limits)	Yes	Age 59½	Yes

Savings Plan Identification

Plan Name	The official Plan name is The Perdue Savings Plan.
Plan Sponsor	The Plan Sponsor is Perdue Farms Inc.
Type of Administration	The Plan is administered by Principal.
Plan Administrator	The Perdue Farms Inc. Investment Committee 31149 Old Ocean City Road Salisbury, MD 21804 410-543-3000
Trustee	The Plan's Trustee is: Delaware Charter Guarantee & Trust Company d/b/a Principal Trust Company 1013 Centre Road, Suite 300 Wilmington, DE 19805-1265
Collective Bargaining Agreements	The terms of the Plan, as set forth in this SPD, apply to employees entitled to participate in the Plan under the terms of the collective bargaining agreements with the following: <ul style="list-style-type: none"> • Golden State United Food and Commercial Workers Union, Local No. 8, Petaluma, CA • International Association of Machinists and Aerospace Workers, Local 1596, Petaluma, CA
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator or the Plan Trustee.
Plan Records and Plan Year	The Perdue Savings Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Savings Plan is considered a defined-contribution retirement plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Effective Date	The original effective date of the Plan is December 1, 1955. This SPD is effective as of July 1, 2021.
Plan Number	The Plan Number is 001.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

IRS Annual Dollar Limits

For 2021

Annual Compensation Limit	\$290,000
Annual Contribution Limit	\$58,000
Annual Deferral Limit	\$19,500
Annual Catch-Up Deferral Limit	\$6,500
Highly Compensated Employee	\$130,000 paid in 2020
Adjusted Gross Income Limits For Tax Credits	\$66,000 for married filing jointly \$49,500 for head of household \$33,000 for single or married filing separately

THE PERDUE SAVINGS PLAN SUMMARY PLAN DESCRIPTION

For associates covered by collective bargaining agreements with:

- **International Union of Operating Engineers, Local No. 147, Chesapeake, VA**
- **International Longshoreman's Association, AFL-CIO, Local No. 1963, Chesapeake, VA**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de ahorros de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-547-7754 para obtener ayuda.

Revised July 1, 2021

Preface

This is a Summary Plan Description (SPD) of the benefits available under The Perdue Savings Plan (“the Plan”) to associates entitled to Plan participation under the terms of collective bargaining agreements with the following locals:

- International Union of Operating Engineers, Local No. 147, Chesapeake, VA (“Local 147”)
- International Longshoreman’s Association, AFL-CIO, Local No. 1963, Chesapeake, VA (“Local 1963”)

The SPD summarizes the benefits available under the terms of the Plan that are in effect as of July 1, 2021. It explains in non-technical language how the Plan works, and it replaces all prior SPDs for the Plan.

Contribution Types

There are a number of contribution types made under the Plan. The Appendix at the end of this SPD has a full list of contribution-type subaccounts maintained under the Plan. Not all sections of the SPD apply to each contribution type. For any questions, please call the Principal Contact Center at 1-800-547-7754.

IRS Annual Dollar Limits

There are a number of IRS annual dollar limits that apply to the Plan. Each year, these limits may change based on inflation. For updated annual dollar limits, please see the Appendix at the end of this SPD.

More detailed information is provided in the plan document, a copy of which is available upon request. If there is a difference between how the SPD and the plan document describe the eligibility rules and the benefits being provided under the Plan, the plan document will control and govern the operation of the Plan.

In this SPD, Perdue Farms Inc. is referred to as the “Plan Sponsor,” each of Perdue’s related companies is referred to as a “Perdue Company,” and each Perdue Company that has adopted the Plan to allow its eligible associates to participate is referred to as a “Participating Company.”

The Plan Sponsor has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and your collective bargaining agreement).

If you have questions regarding your benefits, call the Principal Contact Center at 1-800-547-7754. Participation in the Plan is neither an offer nor a guarantee of future employment.

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Introduction

The Plan enables you to save money for retirement while taking advantage of current tax laws, once you meet the eligibility requirements. Not only do your earnings grow on a tax-deferred basis (you don't pay taxes on your earnings until you withdraw them from your Plan account), you can reduce your current income taxes just by making before-tax contributions to the Plan. And, when you make before-tax contributions or Roth contributions to your account in the Plan, your employer matches a portion of those contributions.

Although the money in your account is meant to fund your retirement, you may be able to access some of the funds before termination of employment through loans or withdrawals (when you have a severe financial hardship or reach age 59½, or otherwise).

Eligibility and Enrollment

This section outlines the Plan's rules of eligibility for associates to participate.

Eligible Associates

You are eligible to participate in the Plan if you are an eligible associate of a Participating Company entitled to Plan participation under the terms of the collective bargaining agreement with Local 147 or Local 1963.

Get the Most from the Plan

If you are an eligible associate, you must contact Principal by calling 1-800-547-7754 to enroll in the Plan or enroll online at www.principal.com. To use the Plan to your best advantage, you must contribute to the Plan regularly. Read on to learn how.

When You May Contribute and Receive Company Matching Contributions

In order to begin saving for your future by contributing to your Plan account and receiving Company matching contributions, you must also:

- Be at least 21 years old; and
- Have completed at least one year of "eligibility service."

You become eligible to contribute on the first day of any calendar quarter (i.e., January, April, July, October) after (or upon which) you meet the above requirements.

To receive Company matching contributions, you must make 401(k) deferrals (before-tax or Roth contributions) to the Plan.

Eligibility Service

You complete a year of eligibility service if you are credited with at least 1,000 hours of service during the 12-month period that ends on:

- The first anniversary of your date of hire with a Perdue Company, or
- Any December 31 (the last day of the "Plan Year"), if you did not complete at least 1,000 hours of service during the 12-month period following your date of hire.

Examples: Mr. Jones begins employment on February 1, 2021. By January 31, 2022, he has completed at least 1,000 hours of service, so he has completed the eligibility service requirement on that date. The next quarterly entry date is April 1, 2022.

Mr. Smith begins employment on February 1, 2021, but has not completed 1,000 hours of service by January 31, 2022. The next 12-month evaluation period is calendar year 2022. Mr. Smith completes at least 1,000 hours of service during calendar year 2022, so he has completed the eligibility service requirement on December 31, 2022. The next quarterly entry date is January 1, 2023.

Hour of Service

You are credited with an “hour of service” for each hour you are either paid or entitled to be paid by a Perdue Company. You may be credited with hours of service for time you do not work and are not paid, such as a layoff of less than one year and approved leaves under the Family and Medical Leave Act or the Uniformed Services Employment and Re-employment Rights Act. Except for approved military leaves, you may not be credited with more than 501 hours of service for a single period that you are not working.

Break in Service

You have a one-year break in service for any calendar year in which you are credited with 500 hours of service or less.

Naming Your Beneficiary

A beneficiary is the person who receives the money in your account if you die. You should name a primary beneficiary to ensure that your benefits are distributed according to your wishes. It is also important to name a contingent beneficiary who will receive your benefits if your beneficiary dies before you.

You may designate (or change) your primary beneficiary and/or contingent beneficiary online by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

If you are married and at any time you want to name someone other than or in addition to your spouse as your primary beneficiary, your spouse must give consent, witnessed by a notary. This is required by federal law.

If you are not married and you do not name a beneficiary, no valid designation of beneficiary exists, or your beneficiaries are no longer living, the Plan will pay your account balance to your estate.

Contributions to the Plan

The Plan and IRS rules govern both the type and amount of contributions that you and your employer may make to the Plan.

Your Compensation

Both you and your employer contribute to the Plan to build your benefit. The amount you contribute is a percentage of your “compensation.” Your compensation is your pay from a Participating Company reportable on Form W-2, Box 1, plus the before-tax contributions you make toward employer benefit programs. But your compensation does not include amounts you receive from a Participating Company as fringe benefits, taxable welfare benefits, expense allowances or severance pay.

In addition, the IRS limits your compensation for purposes of Company contributions to the Plan. This means that your Company matching contributions for a year will not exceed the annual compensation limit multiplied by the matching contribution rate. See the Appendix for the annual compensation limit.

The IRS annual compensation limit does not impact your ability to make before-tax, Roth, or after-tax contributions (which are subject to the other limits described in this SPD).

Annual Contribution Limits

The IRS also limits the amount that **you and your employer** may contribute to the Plan in a calendar year. This limit is the lesser of:

- 100% of your compensation; or
- An annual dollar limit. This annual dollar limit applies to contributions to all of the Perdue Company tax-qualified plans in which you participate during a calendar year; see “Contributing to Another Tax-Qualified Plan in the Same Year.” See the Appendix for the annual contribution limit.

Please note: Rollover contributions (described below) do not apply to these annual limits.

Your Contributions to the Plan

When you are eligible to contribute to the Plan (see “When You May Contribute”), you may contribute a percentage of your compensation to the Plan from each Participating Company paycheck. You may contribute as little as 1% or as much as 75% of your compensation, in whole percentages, as before-tax deferrals, Roth deferrals, and/or after-tax contributions. You may change the amount you contribute at any time.

Your Before-Tax 401(k) Deferrals

Your before-tax 401(k) deferrals come from your pay before federal (and most state and local) income taxes are figured. Unlike your before-tax contributions to other employer benefit plans, your 401(k) deferrals are subject to Social Security and Medicare taxes (FICA withholding).

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as 401(k) deferrals (before-tax and Roth combined). See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals (before-tax and Roth) (not your after-tax contributions).

Your Roth 401(k) Deferrals

Your Roth deferrals come from your pay after federal, state and local income taxes are figured, and are subject to Social Security and Medicare taxes (FICA withholding). Unlike before-tax contributions, these contributions and their earnings are not taxable when they are distributed to you, as long as certain tax law requirements are met. This means that this portion of your retirement savings is able to grow tax-free and that you do not have to pay taxes on it when you receive the money, as long as certain tax law requirements are met.

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as 401(k) deferrals (before-tax and Roth combined). See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals and Roth deferrals only (not your after-tax contributions).

Your After-Tax Contributions

Your after-tax contributions are deducted from your pay after taxes are figured.

If you are a “highly compensated employee” as defined by IRS rules, your after-tax contributions may be limited in order for the Plan to meet non-discrimination tests. You are a highly compensated employee if your compensation from Perdue Companies for the prior year exceeded the threshold amount specified by the IRS for the year. See the Appendix for the highly compensated employee threshold amount. If the Plan fails a non-discrimination test and your after-tax contributions must be limited, you will be notified.

Note: After-tax contributions are not matched by your employer.

Your Rollover Contributions

You may make a rollover contribution to the Plan at any time. Rollover contributions are transfers of money from another tax-qualified plan – such as a former employer’s 401(k) plan or an individual retirement account – to this Plan. Rollover contributions must be transferred from your former plan or provided by you within 60 days after you receive the distributions from your former plan. You may make a rollover contribution of pre-tax, Roth, or after-tax funds from a former employer’s plan, and you may make a rollover contribution of pre-tax funds (but not after-tax funds or Roth funds) from an individual retirement account. If you wish to make a rollover contribution of Roth or after-tax funds from a former employer’s plan, the funds must be transferred directly from your former employer’s plan.

Amounts you transfer to the Plan as a rollover contribution do not count against any Plan or IRS contribution limit, and they are not matched by any Company contribution.

The tax laws and rules involving rollovers are complex. Whether you can, or even should, roll over an amount you previously received is a question you should discuss with your personal tax advisor, because each person’s circumstances differ.

For more information or to make a rollover to the Plan, call the Principal Contact Center at 1-800-547-7754.

Note: Rollover contributions are not matched by your employer.

Example: Ms. Jones is eligible to participate in the Plan. Ms. Jones has a personal individual retirement account (IRA) with a balance of \$50,000 of pre-tax funds. In addition to making 401(k) deferrals and receiving matching contributions, she may have her IRA custodian transfer the \$50,000 to her Plan account, as a rollover contribution. The transferred funds (as adjusted for earnings and losses) will be separately accounted for as a subaccount within her Plan account. Her rollover contribution will not affect the amount she is otherwise eligible to contribute as 401(k) deferrals, and will not be matched.

Your Catch-Up Contributions

During any calendar year in which you are age 50 or older, you may make catch-up contributions to the Plan. These are before-tax contributions, but they do not count toward the IRS dollar limit that generally applies to your 401(k) deferrals, the Plan's 75% of compensation contribution limit, or the IRS overall annual contribution limit (100% of your pay, or the annual contribution limit for the year).

The IRS has a dollar limit for catch-up contributions. Therefore, if you are age 50 or older, you may contribute up to the combined amount of the annual deferral limit and the annual catch-up deferral limit. The IRS allows catch-up contributions to allow people to save more for retirement in their later working years.

See the Appendix for each of the limits discussed in this section.

Note: Catch-up contributions are matched by your employer on the same terms as other before-tax contributions.

Tax Credit for Your Contributions

You may be entitled to a tax credit for your contributions to the Plan, in addition to the tax savings from these before-tax contributions. The federal tax credit is available only if your "adjusted gross income" for tax purposes is below certain limits, which are set forth in the Appendix.

This tax credit ranges from 10% to 50% of the first \$2,000 (\$4,000 if married filing jointly) you contribute to the Plan (either before-tax or after-tax) for the calendar year, depending on how you file your tax return. You must meet certain conditions to qualify for this tax credit; please consult your tax advisor.

Company Matching Contributions

When you make before-tax or Roth contributions to the Plan, your employer makes matching contributions to your Plan account. These contributions are considered "safe harbor" matching contributions under IRS rules.

Your employer provides a match of 100% of your before-tax and/or Roth contributions each pay period, up to 5% of your eligible pay for the pay period. The match is calculated each pay period as follows:

If you are eligible for the match from the first day of the Plan Year: Each pay period, your employer will determine how much total eligible compensation you have received for the year (including that pay period), and how much you have contributed as before-tax and/or Roth contributions for the year (including that pay period). Your employer will provide a match, each pay period, sufficient to bring your total, year-to-date match up to your total, year-to-date before-tax and/or Roth contributions, subject to the limit of 5% of your year-to-date eligible compensation. See the Appendix for an example.

If you become eligible for the match during the Plan Year: Each pay period, your employer will determine how much total eligible compensation you have received for the year *on or after your match eligibility date* (including that pay period), and how much you have contributed as before-tax and/or Roth contributions for the year *on or after your match eligibility date* (including that pay period). Your employer will provide a match, each pay period following your match eligibility date, sufficient to bring your total, year-to-date match up to your total before-tax and/or Roth contributions *made on or after your match eligibility date*, subject to the limit of 5% of your eligible compensation received for the year *on or after your match eligibility date*. See the Appendix for an example.

As explained above in the section entitled “Your Compensation,” your annual match cannot exceed the amount determined by applying the match formula to the IRS annual compensation limit (set forth in the Appendix).

Managing Your Plan Account

The Plan's Trustee, Principal Trust Company, holds in trust all the assets of the Plan. When you become an eligible associate, Principal sets up a separate account in the Plan for you. Your Plan account is used to hold your Plan benefit.

Investing Your Plan Account

As a participant, you are responsible for directing the manner in which the funds are invested. Because the Plan is a "tax-qualified plan" under IRS rules, you defer paying taxes on the investment earnings while they remain in your Plan account.

You may invest your Plan account among a menu of investment funds. You can place 100% of those amounts in one fund or spread your investment in multiples of 1% among all the funds – just make sure your total investments add up to 100%.

You may change your investment decisions at any time. You also may make separate investment elections for your current account balance and for your future contributions to the Plan. Any changes you make become effective as soon as administratively feasible. Make your investment elections online at www.principal.com, or by calling the Principal Contact Center at 1-800-547-7754. Expenses of administering the Plan and trust may be paid from the trust fund. Fees and costs associated with the investment of your account may be charged to your Plan account.

Short-Term Trading Is Prohibited

The Plan is designed for retirement savings, not for short-term investments. The Plan Administrator and Trustee monitor investment changes and have the right to place restrictions on participants whose trading patterns appear to be short-term only and not in keeping with the Plan's intent.

In addition, some investment funds may have certain restrictions or charge a "short-term trading redemption fee" when money is transferred from a fund shortly after being deposited. Please see the prospectus of the investment funds you choose to understand any restrictions or fees related to short-term trading.

Information about the investment funds is available on the Principal website at www.principal.com.

The "Default" Investment Fund

If you do not choose how to invest your account, your account will be automatically invested in a qualified default investment fund that meets the requirements outlined in the Department of Labor's regulations. If you remain in the default investment fund, you may transfer out of this investment to another Plan investment fund at a later time.

How to Make Your Investment Choices

By phone: Call the Principal Contact Center at 1-800-547-7754.

Online: Use the secure Principal at www.principal.com.

Choosing Investment Funds Is Your Responsibility

The Plan is intended to comply with Section 404(c) of Employee Retirement Income Security Act (ERISA) and the Department of Labor's final regulation on "qualified default investment

alternatives” (QDIAs). This means you are legally responsible for your investment choices. Because the Plan complies with this section of ERISA, the fiduciaries of the Plan, including the Plan Sponsor, the Trustee, and the Plan Administrator, will be relieved of any legal liability for any losses that are the direct and necessary result of the investment directions that you give.

When you direct the investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your Plan account does not share in the investment performance of other participants who have directed their own investments.

Your Plan account will be updated for investment earnings or losses each day that the applicable investment markets are open.

The Plan Administrator has established participant direction procedures setting forth investment choices available to you, the frequency with which you can change your investment choices, and instructions on how you can obtain other important information on directed investments. These procedures are provided to you when you enroll in the Plan. It is important that you carefully follow the election procedures in order to ensure that your elections are properly indicated. If you have questions about these procedures, contact the Principal Contact Center at 1-800-547-7754 or by logging onto www.principal.com.

You are not required to direct investments. If you choose not to direct investments, then your account will be invested in the “default” investment fund (as described above).

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. There are no guarantees of performance. The Plan Sponsor, the Plan Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

You can check your account balance, make investment elections or changes or request information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

A personal identification number (“PIN”) is assigned to each Plan participant. This PIN and your Social Security Number will allow you to access your account via the secure website (www.principal.com). You also can reach an account representative by phone at 1-800-547-7754.

Receiving Plan Investment Information

To comply with Section 404(c) of ERISA and the 404(c) Regulations, the Plan names the Plan Administrator – the Perdue Farms Inc. Investment Committee – as the fiduciary (“404(c) Fiduciary”) responsible for providing Plan investment information upon request of you or your beneficiary. You may obtain information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

In addition to the material you receive from the Plan, you have the right to request additional information (available at no cost) to help you decide which investment options to select. The information you may request includes:

- A description of the annual operating expenses of each investment alternative (for example, investment management fees, administrative fees) which reduce your rate of

return, and the aggregate amount of expenses expressed as a percentage of average net assets of the investment alternative.

- Copies of any prospectuses, financial statements and reports, and any other materials relating to the investment alternatives, to the extent this information is provided to the Plan.
- With respect to each investment alternative, a list of assets that make up the portfolio, the value of each asset (or the proportion of the investment alternative to which it belongs); and with respect to each asset which is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term and the rate of return on the contract.
- Information concerning the value of shares or units in the investment alternatives, and information about the past and current investment performance, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment alternative held in your Plan account.

Vesting in Your Plan Account

“Vesting” means your right to receive the value of your Plan account. You are always 100% vested in your entire Plan account, which means that your Plan account may not be forfeited or taken from you. But please note that the value of your Plan account may go up or down, based on the value of the Plan’s investment funds you have chosen.

Receiving Money from the Plan While You Are Working

The purpose of the Plan is to help you save money for retirement years, but it includes features that allow you to receive money from your Plan account while you are still working for the Perdue Companies.

Plan Loans

You may borrow from your Plan account and use the money for any purpose. The Plan has a written loan policy that explains the rules governing Plan loans in detail; for a copy, call the Principal Contact Center at 1-800-547-7754.

Your Plan loan cannot be more than the lesser of:

- One-half of your Plan account at the time of the loan; and
- \$50,000, *minus* your highest outstanding Plan loan balance during the past 12 months.

The minimum loan allowed by the Plan is \$1,000. You may have only one Plan loan at a time. No more than two loan applications may be approved during any calendar year and a minimum of one month must pass between the dates that one loan is paid off and a new loan is applied for. A \$75 loan processing fee is charged for each loan from the Plan.

All Plan loans must be repaid within five years, with interest. You repay your loans by payroll deduction, but you may repay your loan in full, without penalty, with a cashier's check or money order made payable to Principal Trust Company, the Trustee.

Non-Hardship Withdrawals

You may withdraw certain funds from your Plan account if you meet the requirements set out by the Plan and/or the IRS. All or a portion of any withdrawal from your Plan account is taxable to you; see "Taxes on Your Plan Benefits" for details.

The table in the Appendix of this SPD includes short descriptions of the accounts and the distribution options available for each account. For more information on which types of accounts, if any, may be eligible for a non-hardship withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Age 59½ or Older

When you are age 59½ or older, you may withdraw money from these funds in your Plan account at any time, without proving a financial hardship:

- Your 401(k) deferrals (before-tax and Roth);
- Your rollover contributions; and
- Company matching contributions.

Taxes are withheld from your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

The table in the Appendix of this SPD includes short descriptions of the accounts and the distribution options available for each account. For more information on which types of accounts, if any, may be eligible for an age 59½ (or older) withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Younger than Age 59½

If you are not yet age 59½ and you do not have a financial hardship, you may withdraw only the following funds in your Plan account:

- After-tax **matched** contributions you made to the Plan more than two years ago;
- After-tax **unmatched** contributions you made to the Plan; and
- After-tax rollover contributions you rolled over to this Plan.

Taxes are withheld from the taxable portion of your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

Hardship Withdrawals

You may make a hardship withdrawal of certain funds in your Plan account if you meet the requirements set out by the Plan and/or the IRS. Hardship withdrawals are allowed only when you need to pay:

- Medical expenses not covered by insurance, for you or your dependents;
- Costs directly related to the purchase of your home – but not for regular mortgage payments;
- College tuition, fees, and room and board expenses for you or your dependent for the next 12 months;
- Expenses to prevent your eviction or foreclosure on your home;
- Funeral or burial expenses for your parent, spouse or dependent;
- Expenses to repair uninsured damage to your home resulting from a natural disaster; or
- Expenses and losses (including loss of income) you incur due to a disaster declared by FEMA, if your principal residence or place of employment is located in an area designated by FEMA for individual assistance.

To qualify for a hardship withdrawal, you must show that you have first exhausted all other sources of funds to meet your need, including distributions (but not loans) from the Plan. You may withdraw only the amount needed to meet your financial need, including amounts you must pay in taxes and penalties on your withdrawal. The Plan Administrator requires documentation from a third party to justify your financial need.

Taxes are not required to be withheld from your hardship withdrawal, and it is not eligible for tax-deferred rollover.

See the table in the Appendix of this SPD for details about the contribution types that are eligible for a hardship withdrawal, or call the Principal Contact Center at 1-800-547-7754.

Receiving Your Benefit from the Plan

Because the Plan is designed to help fund your retirement, the Plan's benefits are payable when you reach age 65, the Plan's normal retirement age. But you may receive your benefit from the Plan before or after that date, depending on your personal circumstances.

The Plan pays benefits in a single lump sum. Also, you may take partial distributions of your account (subject to the Plan's administrative procedures).

To file a claim for benefits from the Plan, contact the Principal Contact Center at 1-800-547-7754. See the section "Claims" for more information.

When You Retire or Become Disabled

You may receive your Plan benefit when you retire at age 65 or older, or when you become totally and permanently disabled under the terms of a Perdue Company disability plan or Social Security.

When Your Employment Ends

If your employment ends before you reach age 65, you may receive your Plan benefit. When your employment ends, Principal sends you information about how to receive your Plan benefit. You will have the option of rolling over your Plan benefit to another tax-qualified plan, as described in "Rolling Over Your Benefit to Another Plan."

The value of your Plan account determines your options for receiving your Plan benefit.

Options for Deferring Your Benefit

If your employment ends and you wish to defer receiving your Plan benefit, you may do so until you reach your "required beginning date" (see below). Call the Principal Contact Center at 1-800-547-7754 for more information about the "required minimum distribution" rules.

When Your Plan Account Is More Than \$5,000

If the value of your Plan account (excluding any rollover contributions into the Plan) is more than \$5,000 when your employment ends, you may receive your Plan benefit at any time, but generally not later than your "required beginning date", which is the April 1st of the year following the later of the year in which you attain age 72 (70½, if you reached such age by December 31, 2019), or the year in which you terminate employment. At that time, you may take a lump sum distribution, or partial distributions, as long as they are sufficient to meet the "required minimum distribution" rules. You continue to direct the investment of your Plan account, using the same investment options offered to all other Plan participants.

When Your Plan Account Is Between \$1,000 and \$5,000

If your Plan account is more than \$1,000, but not more than \$5,000 (excluding any rollover contributions into the Plan) when your employment ends, you must receive your benefit from the Plan. Principal will send you information about your options for receiving your benefit from the Plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If you do not tell Principal how you want to receive your Plan benefit, your Plan benefit will be rolled over to an individual retirement account (IRA). The Plan Administrator has chosen the Total IRA program, offered by The Mid Atlantic Trust Company, as the automatic IRA to receive your rollover. Your rollover funds will be invested in a type of investment designed to preserve principal and provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund), unless you elect other investments.

All fees and expenses related to this rollover IRA and the IRA investments will be allocated solely to you, as the IRA holder. You may transfer the IRA to another IRA of your choosing.

For more information regarding the Plan's automatic rollover provisions, the IRA provider and fees and expenses attendant to the IRA, call the Principal Contact Center at 1-800-547-7754.

When Your Plan Account Is \$1,000 or Less

If your Plan account is \$1,000 or less when your employment ends, you must receive your benefit from the Plan. Principal will notify you of your right to roll over your Plan benefit to a rollover IRA or another tax-qualified plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If You Die

If you have a balance in your Plan account when you die, the Plan will pay it to your beneficiary (described in "Naming Your Beneficiary"). Your beneficiary may make periodic withdrawals, or defer receiving your Plan benefit, but no longer than shown here (if you die after December 31, 2019):

- **When your beneficiary is your spouse**, he or she may defer receiving your Plan benefit until the *later of*:
 - The end of the first complete calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules;
 - The end of the calendar year in which you would have reached age 72 (your "required distribution date"), with annual distributions in amounts that satisfy the required minimum distribution rules; or
 - The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is an "eligible designated beneficiary" other than your spouse**, the Plan benefit must begin by the later of:
 - December 31 of the calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules; or

- The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is not an “eligible designated beneficiary”**, the Plan benefit must be distributed by the end of the tenth calendar year following the calendar year of your death.
- **An “eligible designated beneficiary”** is your surviving spouse, your child who has not reached the age of majority at your death, a chronically ill individual (as defined by the Internal Revenue Code), or any other individual who is not more than ten years younger than you.

Rolling Over Your Benefit to Another Plan

If your employment ends and you take a distribution of your Plan account, you have the option to roll over your Plan benefit to another tax-qualified plan, such as a Rollover IRA or another employer’s tax-qualified plan, such as a 401(k), 403(b), or a governmental 457(b) plan.

There are two ways to make a rollover from the Plan:

Indirect Rollover

When you receive a distribution from the Plan, you have 60 days to roll over that distribution to another tax-qualified plan. If you wait more than 60 days to complete your rollover, the full value of your distribution from the Plan becomes taxable to you.

The Plan is required to withhold 20% of the distribution of your Plan benefit for federal income taxes. (Additional state-level mandatory tax withholding may also apply.) In order to defer taxes on the full value of your Plan benefit, you must roll over 100% of your Plan benefit within the 60-day limit. This means you will have to use other funds with your rollover contribution to make up the 20% withheld for taxes, otherwise the 20% withheld will become taxable to you.

Direct Rollover

You may avoid tax withholding by electing a direct rollover of your account to another tax-qualified plan or account. With a direct rollover, your funds are transferred directly to the new plan or account, and you do not take possession of them.

Taxes on Your Plan Benefits

The Plan is a “tax-qualified plan” under IRS regulations. This means that much of the money in your Plan account (other than Roth and after-tax contributions)—including Company contributions and investment earnings—is sheltered from income taxes until you take it from the Plan (and is further sheltered if you do a direct rollover as discussed above). This section describes how taxes affect your benefits when you receive them from the Plan, according to tax laws in effect at the time this SPD was written.

Ordinary Income Taxes

Before-tax deferral contributions, Company contributions, and their investment earnings are subject to federal, state and local income taxes upon distribution. Roth deferral contributions are income tax-free upon distribution, and their investment earnings may potentially be income-tax free upon distribution, if IRS requirements are satisfied (and if permitted by state/local law). After-tax contributions are tax-free upon distribution, but their investment earnings are taxable upon

distribution. Taxation may be deferred through a rollover to another employer-sponsored retirement plan or an individual retirement account.

For distributions that are not directly rolled over, the Plan is required to withhold 20% of the taxable amount as federal income tax withholding. Additional state and local mandatory withholding may also apply.

Tax treatment and rollover rules are complex, vary based on contribution type and the type of account receiving the rollover, and are subject to change. You will receive additional information when you are ready to take a distribution, and should consult with a tax advisor for assistance.

Additional 10% Tax

If you receive a distribution from the Plan before you reach age 59½ – as a Plan benefit or as a hardship withdrawal – that distribution may be subject to an additional 10% federal tax for an “early distribution,” sometimes referred to as a “penalty tax,” if it is not rolled over. This additional 10% tax does not apply, however, if your distribution is:

- Paid due to your disability;
- Paid as a series of equal payments over your life or life expectancy (or your and your beneficiary's lives or life expectancies);
- Used to pay certain tax-deductible medical expenses;
- Paid directly to the government to satisfy a federal tax levy;
- Paid to you during a period of at least 180 days of active military duty; or
- Paid to an “alternate payee” under a Qualified Domestic Relations Order (see “Receiving a Qualified Domestic Relations Order”).

More information about the additional 10% federal tax is found on IRS Form 5329.

You will receive a more comprehensive notice describing tax issues when you are electing your distribution.

Events That May Affect Your Benefit

This section outlines events that may affect your benefit from the Plan.

Military Leave of Absence

Generally, if you return to active employment with a Perdue Company after a period of military service of less than five years, your period of military service will count toward your vesting service, so long as you return to work within the time provided by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Beginning with your return to active work with a Perdue Company, you have a period equal to five years (or, if shorter, three times your period of military service) to make up the contributions you could have made to the Plan during that time. Your compensation for the period of your military service is assumed to be the amount you would have received from the Participating Companies if you had remained an active associate during your period of military service.

If you make up your 401(k) deferrals, your employer will make Company matching contributions equal to the amount you would have received if you worked during your military leave. You are not, however, credited with past investment earnings for those made-up contributions.

Contributing to Another Tax-Qualified Plan in the Same Year

Your before-tax and Roth contributions (combined) to tax-qualified plans are limited to a dollar amount each calendar year (see “Your Before-Tax 401(k) Deferrals”). Your 401(k) deferrals count toward this annual limit, as well as any before-tax or Roth contributions you make to another employer’s 401(k) plan, Section 408(k) simplified employer pension plan, Section 403(b) annuity contract, or elective employer contributions under Section 408(p)(2)(A)(i) of the Internal Revenue Code.

If you have contributed to another employer’s tax-qualified plan during the same year you make 401(k) deferrals to this Plan, you may need to reduce your 401(k) deferrals so that you do not exceed the limit.

You have until March 1 of the following year to notify your former employer or Principal to request a refund of excess contributions. The excess amount, plus any investment gain or loss, will be issued to you no later than April 15. For more information, call the Principal Contact Center at 1-800-547-7754.

Receiving a Qualified Domestic Relations Order

A Qualified Domestic Relations Order (or “QDRO”) is a court order that provides child support, alimony or marital property rights to a spouse, former spouse or dependent from your Plan account. A QDRO must be issued pursuant to a state domestic relations law and must meet certain technical requirements. A QDRO cannot require the Plan to provide any type or form of payment, or any option, not permitted by the Plan (although it can require payment before you terminate employment).

Under a QDRO, a former spouse may be entitled to the same rights as a current spouse, with respect to some or all of your account. If this is the case, then any provisions in the Plan that require spousal approval, such as naming a nonspouse beneficiary or (if applicable) choosing

certain optional forms of payment, may apply to your former spouse with respect to the portion of your account designated for the former spouse (see “Naming Your Beneficiary”).

The Plan Administrator will determine whether an order meets the requirements of a QDRO. While the Plan Administrator is making this determination, you may be prohibited from receiving a distribution from the Plan.

If it appears that you may be subject to a QDRO, you should call the Corporate Benefits Line at 1-800-997-3247. You can obtain, without charge, a copy of the Plan's QDRO procedures. Your account may be charged a \$600 fee for processing the QDRO, and this fee will be charged before your account is divided and the order is implemented. Information about the fee will be included in the Plan's QDRO procedures.

If the Plan Fails Non-Discrimination Testing

Federal law requires the Plan to pass certain non-discrimination tests each year. These tests are done to ensure the Plan does not discriminate in favor of highly compensated associates.

If the Plan fails these tests, it may have to refund contributions to some highly compensated associates. If these rules affect you, you will be notified.

If the Plan Terminates

If the Plan terminates, your Plan benefit will remain fully vested, and the assets of the Plan will be used solely to provide benefits to you, other Plan participants and designated beneficiaries after any expenses of the Plan have been paid. Your benefits will be paid to you as soon as practical. After all assets have been distributed, the Trustee has no more responsibilities under the Plan, and neither you nor your beneficiary will have any further claim to the Plan.

Loss of Benefits

You may lose benefits from the Plan due to poor investment experience, the application of IRS limits, the imposition of taxes or penalties on your benefits, or the application of a QDRO.

Claims

The Plan Administrator has established these procedures for filing claims for benefits available under the Plan. ***Failure to follow these procedures within the required time periods will result in the loss of your right to sue in court.***

When a claim exists, you, your beneficiary or an authorized representative may call the Principal Contact Center at 1-800-547-7754, or access the Principal website at www.principal.com to start the claims process. The Plan Administrator will respond to the claim in writing within 90 days of the submission, stating whether you are eligible for benefits under the Plan. If the Plan Administrator determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator may extend this response period by up to 90 days and will notify you of the special circumstances and the date by which a decision is expected to be made.

Decisions on Claims

You will receive a decision on your claim in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan Administrator's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination; and
- Demonstrate compliance with the Plan Administrator's processes or safeguards.

Appealing a Claim

The Plan wants to be sure that you and your beneficiaries receive the full benefits for which you are eligible under the Plan.

If an initial claim for benefits under the Plan is denied, in whole or in part, in a letter from a Claims Administrator or otherwise, you have 60 days to appeal the denial. Your appeal must be in writing and should contain the reasons why you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits. Within 60 days after receiving your appeal, the Plan Administrator will give you (and your counsel, if any) an opportunity to present your position to the Plan Administrator in writing, and an opportunity to review any pertinent documents.

The Plan Administrator will notify you of its decision in writing within the 60-day period, stating specifically the basis of the decision and the specific provisions of the Plan on which the decision

is based. If because of special circumstances requiring additional time to make a decision the 60-day period is not sufficient, the decision may be deferred for up to another 60 days at the election of the Plan Administrator, and you will be notified of the delay.

If your claim is denied on appeal, you will receive written notice of the Plan Administrator's final decision on your claim, which contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A statement that you may request, free of charge, reasonable access to and copies of all relevant documents, records and information; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA.

You must exhaust all of the procedures described above before pursuing the claim in any other proceeding.

You cannot file a civil action pursuant to ERISA Section 502(a)(1)(B), with respect to a benefit under the Plan, more than two years after your appeal is denied (or deemed denied).

Any civil action to obtain a benefit under ERISA Section 502(a)(1)(B) must be filed in the United States District Court for the District of Maryland, and the law as stated and applied by the United States Court of Appeals for the Fourth Circuit or the United States District Court for the District of Maryland will govern.

Any claim under ERISA or otherwise with respect to the Plan (other than a claim for benefits under ERISA Section 502(a)(1)(B)) shall be submitted to binding arbitration, on an individual (non-class) basis, within two years after the claim arises (or within such shorter period otherwise applicable to the claim).

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You will receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You will receive a quarterly statement setting forth your Plan account balances.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

Your assets pay investment management fees, which are disclosed in the applicable prospectus for each investment fund. You also pay for routine administrative costs, as well as special fees (such as for processing QDROs). A fee disclosure document will be provided each year.

Funds in the Plan are held in trust for participants and their beneficiaries. The Trustee pays all benefits under the Plan from available assets in the trust. Contributions from participants and Participating Companies go into a trust fund managed under the terms of a trust agreement with the Plan's Trustee.

The Plan Is Not Insured

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), a corporation was established to insure the benefits promised under certain types of pension plans. The corporation is known as the Pension Benefit Guaranty Corporation ("PBGC").

Under present law, the PBGC cannot insure the benefits under this Plan because it is a profit sharing plan in which the benefits you receive are based on your actual account balances. The PBGC insures only "defined benefit pension" plans.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Perdue Companies and any associate. As an "at-will employee," either your employer or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Document Governs

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the plan document that determines your rights and the rights of your dependents under the Plan. In the event of a discrepancy between this summary plan description and the plan document, the plan document will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon any Perdue Company or which alters the Plan or other documents maintained in conjunction with the Plan.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment, to the extent permitted by applicable law.

Assignment of Benefits

Neither you nor your beneficiary may assign your benefits under the Plan. Generally, the Plan and its benefits may not be seized to pay your debts or obligations unless you elect a withdrawal

from your Plan account. However, the Plan is required to honor a QDRO, described in the section “Receiving a Qualified Domestic Relations Order,” which will reduce the Plan benefit payable to you.

Plan May Be Amended or Terminated

The Plan Sponsor expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time, subject to the terms of the plan document. In addition, the Plan Sponsor does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan shall be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Appendix

Table of Plan Accounts

401(k) Money Types	Account Description	Loans Available?	In-Service Withdrawal Available?	Hardship Withdrawal Available?
401(k)	Your own <i>before-tax</i> contributions to the Plan	Yes	Age 59½	Yes
Roth 401k	Your own <i>Roth</i> contributions	Yes	Age 59½	Yes
Voluntary Unmatched	Your own <i>after-tax</i> contributions that <i>were not</i> eligible for a Company match	Yes	Any age	N/A
Safe Harbor Match	Matching contributions made by the Participating Companies	Yes	Age 59½	Yes
Rollover	Before-tax amounts that you may have received from another employer's retirement plan or an IRA, and chose to transfer to this Plan	Yes	Age 59½	Yes
After-tax Rollover	After-tax amounts that you may have received from another employer's retirement plan, and chose to transfer to this Plan	Yes	Any age	N/A
Catch-Up	Your own additional before-tax contributions to the Plan if age 50 or older (over and above the regular limits)	Yes	Age 59½	Yes

Savings Plan Identification

Plan Name	The official Plan name is The Perdue Savings Plan.
Plan Sponsor	The Plan Sponsor is Perdue Farms Inc.
Type of Administration	The Plan is administered by Principal.
Plan Administrator	The Perdue Farms Inc. Investment Committee 31149 Old Ocean City Road Salisbury, MD 21804 410-543-3000
Trustee	The Plan's Trustee is: Delaware Charter Guarantee & Trust Company d/b/a Principal Trust Company 1013 Centre Road, Suite 300 Wilmington, DE 19805-1265
Collective Bargaining Agreements	The terms of the Plan, as set forth in this SPD, apply to employees entitled to participate in the Plan under the terms of collective bargaining agreements with the following: <ul style="list-style-type: none"> • International Union of Operating Engineers, Local No. 147, Chesapeake, VA • International Longshoreman's Association, AFL-CIO, Local No. 1963, Chesapeake, VA
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator or the Plan Trustee.
Plan Records and Plan Year	The Perdue Savings Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Savings Plan is considered a defined-contribution retirement plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Effective Date	The original effective date of the Plan is December 1, 1955. This SPD is effective as of July 1, 2021.
Plan Number	The Plan Number is 001.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

IRS Annual Dollar Limits

For 2021

Annual Compensation Limit	\$290,000
Annual Contribution Limit	\$58,000
Annual Deferral Limit	\$19,500
Annual Catch-Up Deferral Limit	\$6,500
Highly Compensated Employee	\$130,000 paid in 2020
Adjusted Gross Income Limits For Tax Credits	\$66,000 for married filing jointly \$49,500 for head of household \$33,000 for single or married filing separately

Matching Contribution Examples

If you are eligible for the match from the first day of the Plan Year:

Example: Ms. Jones has satisfied the year of service requirement and is eligible for matching contributions as of January 1, 2021. Her eligible compensation is \$2,500 per bi-weekly pay period. For each of the first four pay periods in 2021, she contributes before-tax 4% of eligible compensation (\$100 per pay, \$400 total), and receives total matching contributions of \$400. For the fifth pay period in 2021, she contributes before-tax 12% of eligible compensation (\$300). Her matching contribution for the fifth pay period is \$225, which is calculated as follows:

Total before-tax contributions for 2021 (year-to-date, including the fifth pay period): \$700

Total eligible compensation for 2021 (year-to-date, including the fifth pay period): \$12,500

5% of total eligible compensation for 2021 (year-to-date, including the fifth pay period): \$625

Match for the fifth pay period: \$225, which is \$625 (the lesser of year-to-date before-tax contributions or 5% of year-to-date eligible compensation), minus the \$400 of match already received for 2021

If you become eligible for the match during the Plan Year:

Example: Ms. Smith receives eligible compensation of \$12,000 for each of the 26 bi-weekly pay periods during 2021. She satisfies the year of service requirement and becomes eligible for matching contributions as of the sixth payroll period in 2021. She is under age 50 and not eligible for catch-up contributions, so her annual before-tax contribution limit for 2021 is \$19,500.

For the first five payroll periods in 2021, she has contributed before-tax 12% of her pay (\$1,440 per pay, or \$7,200), and receives no matching contributions because she is not yet eligible. After becoming eligible (beginning with the sixth pay period in 2021), she continues to contribute at a rate of 12% (\$1,440 per pay), and receives matching contributions of \$600 per pay. She reaches the IRS limit on before-tax contributions (\$19,500 for 2021) on the 14th pay period, and can no longer make before-tax contributions for 2021. At that point, she has received matching contributions of \$5,400 (she has been matched for nine pay periods), and cannot receive further matching contributions in 2021 because she can no longer contribute.

Ms. Smith could have maximized her 2021 matching contributions by taking the following steps:

1. Calculating the maximum available match for 2021, by multiplying the 5% match rate by her eligible compensation payable on or after she becomes eligible for the match ($5\% \times \$252,000$ (which is \$12,000 for 21 pay periods)), yielding a maximum available 2021 match of \$12,600. (Had her compensation payable after

she becomes eligible for the match exceeded the 2021 IRS limit of \$290,000, her maximum 2021 match would have been \$14,500.)

2. Ensuring that she is able to contribute at least \$12,600 for 2021 after she becomes eligible for the match, by limiting her 2021 before-tax contributions before she is eligible for the match to \$6,900 (i.e., \$19,500 – \$12,600).

3. Setting her before-tax contribution rate, following her match eligibility date, at a rate that will enable her to contribute for all of the remaining pay periods in 2021, and not reach the maximum before the end of 2021. A 5% before-tax election will yield this result (i.e., \$12,600 divided by 21 payroll periods will allow her to contribute \$600 for each of the 21 payroll periods, and receive the maximum available \$600 match each pay period).

In each of the above examples, any portion of the participant's before-tax contributions could be substituted with Roth contributions.

THE PERDUE SAVINGS PLAN SUMMARY PLAN DESCRIPTION

For associates covered by collective bargaining agreements with:

- **United Food and Commercial Workers Union, Local No. 21, Production Group, Mount Vernon, WA**
- **United Food and Commercial Workers Union, Local No. 21, Distribution Group, Mount Vernon, WA**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de ahorros de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-547-7754 para obtener ayuda.

Revised July 1, 2021

Preface

This is a Summary Plan Description (SPD) of the benefits available under The Perdue Savings Plan (“the Plan”) to associates entitled to Plan participation under the terms of collective bargaining agreements with the following locals:

- United Food and Commercial Workers Union, Local No. 21, Production Group
- United Food and Commercial Workers Union, Local No. 21, Distribution Group (collectively with the Production Group, “Local No. 21”)

The SPD summarizes the benefits available under the terms of the Plan that are in effect as of July 1, 2021. It explains in non-technical language how the Plan works, and it replaces all prior SPDs for the Plan.

Contribution Types

There are a number of contribution types made under the Plan. The Appendix at the end of this SPD has a full list of contribution-type subaccounts maintained under the Plan. Not all sections of the SPD apply to each contribution type. For any questions, please call the Principal Contact Center at 1-800-547-7754.

IRS Annual Dollar Limits

There are a number of IRS annual dollar limits that apply to the Plan. Each year, these limits may change based on inflation. For updated annual dollar limits, please see the Appendix at the end of this SPD.

More detailed information is provided in the plan document, a copy of which is available upon request. If there is a difference between how the SPD and the plan document describe the eligibility rules and the benefits being provided under the Plan, the plan document will control and govern the operation of the Plan.

In this SPD, Perdue Farms Inc. is referred to as the “Plan Sponsor,” each of Perdue’s related companies is referred to as a “Perdue Company,” and each Perdue Company that has adopted the Plan to allow its eligible associates to participate is referred to as a “Participating Company.”

The Plan Sponsor has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and your collective bargaining agreement).

If you have questions regarding your benefits, call the Principal Contact Center at 1-800-547-7754. Participation in the Plan is neither an offer nor a guarantee of future employment.

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Introduction

The Plan enables you to save money for retirement while taking advantage of current tax laws. Not only do your earnings grow on a tax-deferred basis (you don't pay taxes on your earnings until you withdraw them from your Plan account), you can reduce your current income taxes just by making before-tax contributions to the Plan. And when you make before-tax contributions or Roth contributions, your employer matches a portion of those contributions once you meet the eligibility requirements.

Although the money in your account is meant to fund your retirement, you may be able to access some of the funds before termination of employment through loans or withdrawals (when you have a severe financial hardship or reach age 59½, or otherwise).

Eligibility and Enrollment

This section outlines the Plan's rules of eligibility for associates to participate.

Eligible Associates

You are eligible to participate in the Plan if you are an eligible associate of a Participating Company entitled to Plan participation under the terms of a collective bargaining agreement with Local 21. If you are uncertain whether your employer is a Participating Company, call the Principal Contact Center at 1-800-547-7754.

Get the Most from the Plan

If you are an eligible associate, you must contact Principal by calling 1-800-547-7754 to enroll in the Plan or enroll online at www.principal.com. To use the Plan to your best advantage, you must contribute to the Plan regularly. Read on to learn how.

When You May Contribute

In order to begin saving for your future by contributing to your Plan account, you must also:

- Be at least 21 years old; and
- Have worked for a Perdue Company for at least 30 days.

When You May Receive Company Matching Contributions

In order to receive Company matching contributions to your Plan account, you must also:

- Be at least 21 years old; and
- Have completed at least one year of "eligibility service."

You become eligible to receive Company matching contributions on the first day of any calendar quarter (i.e., January, April, July, October) after (or upon which) you meet the above requirements.

To receive Company matching contributions, you must make 401(k) deferrals (before-tax or Roth contributions) to the Plan. You do not need to make contributions to the Plan in order to receive Company discretionary contributions.

Eligibility Service

You complete a year of eligibility service if you are credited with at least 1,000 hours of service during the 12-month period that ends on:

- The first anniversary of your date of hire with a Perdue Company, or
- Any December 31 (the last day of the "Plan Year"), if you did not complete at least 1,000 hours of service during the 12-month period following your date of hire.

Examples: Mr. Jones begins employment on February 1, 2021. By January 31, 2022, he has completed at least 1,000 hours of service, so he has completed the eligibility service requirement on that date. Mr. Jones will begin to receive Company matching contributions as of the next quarterly entry date (April 1, 2022).

Mr. Smith begins employment on February 1, 2021, but has not completed 1,000 hours of service by January 31, 2022. The next 12-month evaluation period is calendar year 2022. Mr. Smith

completes at least 1,000 hours of service during calendar year 2022, so he has completed the eligibility service requirement on December 31, 2022. Mr. Jones will begin to receive Company matching contributions as of the next quarterly entry date (January 1, 2023).

Hour of Service

You are credited with an “hour of service” for each hour you are either paid or entitled to be paid by a Perdue Company. You may be credited with hours of service for time you do not work and are not paid, such as a layoff of less than one year and approved leaves under the Family and Medical Leave Act or the Uniformed Services Employment and Re-employment Rights Act. Except for approved military leaves, you may not be credited with more than 501 hours of service for a single period that you are not working.

Break in Service

You have a one-year break in service for any calendar year in which you are credited with 500 hours of service or less.

Naming Your Beneficiary

A beneficiary is the person who receives the money in your account if you die. You should name a primary beneficiary to ensure that your benefits are distributed according to your wishes. It is also important to name a contingent beneficiary who will receive your benefits if your beneficiary dies before you.

You may designate (or change) your primary and/or contingent beneficiary online by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

If you are married and at any time you want to name someone other than or in addition to your spouse as your primary beneficiary, your spouse must give consent, witnessed by a notary. This is required by federal law.

If you are not married and you do not name a beneficiary, no valid designation of beneficiary exists, or your beneficiaries are no longer living, the Plan will pay your account balance to your estate.

Contributions to the Plan

The Plan and IRS rules govern both the type and amount of contributions that you and your employer may make to the Plan.

Your Compensation

Both you and your employer contribute to the Plan to build your benefit. The amount you contribute is a percentage of your “compensation.” Your compensation is your pay from a Participating Company reportable on Form W-2, Box 1, plus the before-tax contributions you make toward employer benefit programs. But your compensation does not include amounts you receive from a Participating Company as fringe benefits, taxable welfare benefits, expense allowances or severance pay.

In addition, the IRS limits your compensation for purposes of Company contributions to the Plan. This means that your Company matching contributions for a year will not exceed the annual compensation limit multiplied by the matching contribution rate. See the Appendix for the annual compensation limit.

The IRS annual compensation limit does not impact your ability to make before-tax, Roth, or after-tax contributions (which are subject to the other limits described in this SPD).

Annual Contribution Limits

The IRS also limits the amount that **you and your employer** may contribute to the Plan in a calendar year. This limit is the lesser of:

- 100% of your compensation; or
- An annual dollar limit. This annual dollar limit applies to contributions to all of the Perdue Company tax-qualified plans in which you participate during a calendar year; see “Contributing to Another Tax-Qualified Plan in the Same Year.” See the Appendix for the annual contribution limit.

Please note: Rollover contributions (described below) do not apply to these annual limits.

Your Contributions to the Plan

When you are eligible to contribute to the Plan (see “When You May Contribute”), you may contribute a percentage of your compensation to the Plan from each Participating Company paycheck. You may contribute as little as 1% or as much as 75% of your compensation, in whole percentages, as before-tax deferrals, Roth deferrals, and/or after-tax contributions. You may change the amount you contribute at any time.

Your Before-Tax 401(k) Deferrals

Your before-tax 401(k) deferrals come from your pay before federal (and most state and local) income taxes are figured. Unlike your before-tax contributions to other employer benefit plans, your 401(k) deferrals are subject to Social Security and Medicare taxes (FICA withholding).

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as 401(k) deferrals (before-tax and Roth combined). See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals (before-tax and Roth) (not your after-tax contributions).

Your Roth 401(k) Deferrals

Your Roth deferrals come from your pay after federal, state and local income taxes are figured, and are subject to Social Security and Medicare taxes (FICA withholding). Unlike before-tax contributions, these contributions and their earnings are not taxable when they are distributed to you, as long as certain tax law requirements are met. This means that this portion of your retirement savings is able to grow tax-free and that you do not have to pay taxes on it when you receive the money, as long as certain tax law requirements are met.

The IRS limits the dollar amount you may contribute to the Plan during a calendar year as 401(k) deferrals (before-tax and Roth combined). See the Appendix for the annual deferral limit.

Note: Company matching contributions are based on your 401(k) deferrals and Roth deferrals only (not your after-tax contributions).

Your After-Tax Contributions

Your after-tax contributions are deducted from your pay after taxes are figured.

If you are a “highly compensated employee” as defined by IRS rules, your after-tax contributions may be limited in order for the Plan to meet non-discrimination tests. You are a highly compensated employee if your compensation from Perdue Companies for the prior year exceeded the threshold amount specified by the IRS for the year. See the Appendix for the highly compensated employee threshold amount. If the Plan fails a non-discrimination test and your after-tax contributions must be limited, you will be notified.

Note: After-tax contributions are not matched by your employer.

Your Rollover Contributions

You may make a rollover contribution to the Plan at any time. Rollover contributions are transfers of money from another tax-qualified plan – such as a former employer’s 401(k) plan or an individual retirement account – to this Plan. Rollover contributions must be transferred from your former plan or provided by you within 60 days after you receive the distributions from your former plan. You may make a rollover contribution of pre-tax, Roth, or after-tax funds from a former employer’s plan, and you may make a rollover contribution of pre-tax funds (but not after-tax funds or Roth funds) from an individual retirement account. If you wish to make a rollover contribution of Roth or after-tax funds from a former employer’s plan, the funds must be transferred directly from your former employer’s plan.

Amounts you transfer to the Plan as a rollover contribution do not count against any Plan or IRS contribution limit, and they are not matched by any Company contribution.

The tax laws and rules involving rollovers are complex. Whether you can, or even should, roll over an amount you previously received is a question you should discuss with your personal tax advisor, because each person’s circumstances differ.

For more information or to make a rollover to the Plan, call the Principal Contact Center at 1-800-547-7754.

Note: Rollover contributions are not matched by your employer.

Example: Ms. Jones is eligible to participate in the Plan. Ms. Jones has a personal individual retirement account (IRA) with a balance of \$50,000 of pre-tax funds. In addition to making 401(k) deferrals and receiving matching contributions, she may have her IRA custodian transfer the \$50,000 to her Plan account, as a rollover contribution. The transferred funds (as adjusted for earnings and losses) will be separately accounted for as a subaccount within her Plan account. Her rollover contribution will not affect the amount she is otherwise eligible to contribute as 401(k) deferrals for the year, and will not be matched.

Your Catch-Up Contributions

During any calendar year in which you are age 50 or older, you may make catch-up contributions to the Plan. These are before-tax contributions, but they do not count toward the IRS dollar limit that generally applies to your 401(k) deferrals, the Plan's 75% of compensation contribution limit, or the IRS overall annual contribution limit (100% of your pay or the annual contribution limit for the year).

The IRS has a dollar limit for catch-up contributions. Therefore, if you are age 50 or older, you may contribute up to the combined amount of the annual deferral limit and the annual catch-up deferral limit. The IRS allows catch-up contributions to allow people to save more for retirement in their later working years.

See the Appendix for each of the limits discussed in this section.

Note: Catch-up contributions are matched by your employer on the same terms as other before-tax contributions.

Tax Credit for Your Contributions

You may be entitled to a tax credit for your contributions to the Plan, in addition to the tax savings from these before-tax contributions. The federal tax credit is available only if your "adjusted gross income" for tax purposes is below certain limits, which are set forth in the Appendix.

This tax credit ranges from 10% to 50% of the first \$2,000 (\$4,000 if married filing jointly) you contribute to the Plan (either before-tax or after-tax) for the calendar year, depending on how you file your tax return. You must meet certain conditions to qualify for this tax credit; please consult your tax advisor.

Company Contributions to the Plan

Your employer also contributes to your Plan account. Some Company contributions are made automatically, but some are made strictly at your employer's discretion.

Company Matching Contributions

When you make before-tax or Roth contributions to the Plan, your employer makes matching contributions to your Plan account once you have met the eligibility requirements. These contributions are considered "safe harbor" matching contributions under IRS rules.

Your employer provides a match of 100% of your before-tax and/or Roth contributions each pay period, up to 5% of your eligible pay for the pay period. The match is calculated each pay period as follows:

If you are eligible for the match from the first day of the Plan Year: Each pay period, your employer will determine how much total eligible compensation you have received for the year (including that pay period), and how much you have contributed as before-tax and/or Roth contributions for the year (including that pay period). Your employer will provide a match, each pay period, sufficient to bring your total, year-to-date match up to your total, year-to-date before-tax and/or Roth contributions, subject to the limit of 5% of your year-to-date eligible compensation. See the Appendix for an example.

If you become eligible for the match during the Plan Year: Each pay period, your employer will determine how much total eligible compensation you have received for the year *on or after your match eligibility date* (including that pay period), and how much you have contributed as before-tax and/or Roth contributions for the year *on or after your match eligibility date* (including that pay period). Your employer will provide a match, each pay period following your match eligibility date, sufficient to bring your total, year-to-date match up to your total before-tax and/or Roth contributions *made on or after your match eligibility date*, subject to the limit of 5% of your eligible compensation received for the year *on or after your match eligibility date*. See the Appendix for an example.

As explained above in the section entitled “Your Compensation,” your annual match cannot exceed the amount determined by applying the match formula to the IRS annual compensation limit (set forth in the Appendix).

Company Discretionary Contributions

In past years, Participating Companies made discretionary contributions to the Plan. Discretionary contributions are made to the Plan account of each eligible associate who is employed by a Participating Company as of the end of that calendar year. Former eligible associates who died, retired, or terminated employment during the year due to disability are eligible to receive a pro-rated Company discretionary contribution, based on their number of full calendar months of employment during the year.

The amount of the Company discretionary contribution (if any) for any calendar year is determined by the Plan Sponsor based on profitability for the year, and it is contributed as a fixed dollar amount for every eligible participant. Your employer will notify you if a discretionary contribution will be made for any given year.

Note: You are not required to contribute to the Plan to receive a Company discretionary contribution.

Managing Your Plan Account

The Plan's Trustee, Principal Trust Company, holds in trust all the assets of the Plan. When you become an eligible associate, Principal sets up a separate account in the Plan for you. Your Plan account is used to hold your Plan benefit.

Investing Your Plan Account

As a participant, you are responsible for directing the manner in which the funds are invested. Because the Plan is a "tax-qualified plan" under IRS rules, you defer paying taxes on the investment earnings while they remain in your Plan account.

You may invest your Plan account among a menu of investment funds. You can place 100% of those amounts in one fund or spread your investment in multiples of 1% among all the funds – just make sure your total investments add up to 100%.

You may change your investment decisions at any time. You also may make separate investment elections for your current account balance and for your future contributions to the Plan. Any changes you make become effective as soon as administratively feasible. Make your investment elections online at www.principal.com, or by calling the Principal Contact Center at 1-800-547-7754. Expenses of administering the Plan and trust may be paid from the trust fund. Fees and costs associated with the investment of your account may be charged to your Plan account.

Short-Term Trading Is Prohibited

The Plan is designed for retirement savings, not for short-term investments. The Plan Administrator and Trustee monitor investment changes and have the right to place restrictions on participants whose trading patterns appear to be short-term only and not in keeping with the Plan's intent.

In addition, some investment funds may have certain restrictions or charge a "short-term trading redemption fee" when money is transferred from a fund shortly after being deposited. Please see the prospectus of the investment funds you choose to understand any restrictions or fees related to short-term trading.

Information about the investment funds is available on the Principal website at www.principal.com.

The "Default" Investment Fund

If you do not choose how to invest your account, your account will be automatically invested in a qualified default investment fund that meets the requirements outlined in the Department of Labor's regulations. If you remain in the default investment fund, you may transfer out of this investment to another Plan investment fund at a later time.

How to Make Your Investment Choices

By phone: Call the Principal Contact Center at 1-800-547-7754.

Online: Use the secure Principal website at www.principal.com.

Choosing Investment Funds Is Your Responsibility

The Plan is intended to comply with Section 404(c) of the Employee Retirement Income Security Act (ERISA) and the Department of Labor's final regulation on "qualified default investment

alternatives” (QDIAs). This means you are legally responsible for your investment choices. Because the Plan complies with this section of ERISA, the fiduciaries of the Plan, including the Plan Sponsor, the Trustee, and the Plan Administrator, will be relieved of any legal liability for any losses that are the direct and necessary result of the investment directions that you give.

When you direct the investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your Plan account does not share in the investment performance of other participants who have directed their own investments.

Your Plan account will be updated for investment earnings or losses each day that the applicable investment markets are open.

The Plan Administrator has established participant direction procedures setting forth investment choices available to you, the frequency with which you can change your investment choices, and instructions on how you can obtain other important information on directed investments. These procedures are provided to you when you enroll in the Plan. It is important that you carefully follow the election procedures in order to ensure that your elections are properly indicated. If you have questions about these procedures, contact the Principal Contact Center at 1-800-547-7754 or by logging onto www.principal.com.

You are not required to direct investments. If you choose not to direct investments, then your account will be invested in the “default” investment fund (as described above).

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur. There are no guarantees of performance. The Plan Sponsor, the Plan Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

You can check your account balance, make investment elections or changes or request information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

A personal identification number (“PIN”) is assigned to each Plan participant. This PIN and your Social Security Number will allow you to access your account via the secure website (www.principal.com). You also can reach an account representative by phone at 1-800-547-7754.

Receiving Plan Investment Information

To comply with Section 404(c) of ERISA and the 404(c) Regulations, the Plan names the Plan Administrator – the Perdue Farms Inc. Investment Committee – as the fiduciary (“404(c) Fiduciary”) responsible for providing Plan investment information upon request of you or your beneficiary. You may obtain information regarding your investment fund options by logging onto www.principal.com or by contacting the Principal Contact Center at 1-800-547-7754.

In addition to the material you receive from the Plan, you have the right to request additional information (available at no cost) to help you decide which investment options to select. The information you may request includes:

- A description of the annual operating expenses of each investment alternative (for example, investment management fees, administrative fees) which reduce your rate of

return, and the aggregate amount of expenses expressed as a percentage of average net assets of the investment alternative.

- Copies of any prospectuses, financial statements and reports, and any other materials relating to the investment alternatives, to the extent this information is provided to the Plan.
- With respect to each investment alternative, a list of assets that make up the portfolio, the value of each asset (or the proportion of the investment alternative to which it belongs); and with respect to each asset which is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term and the rate of return on the contract.
- Information concerning the value of shares or units in the investment alternatives, and information about the past and current investment performance, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment alternative held in your Plan account.

Vesting in Your Plan Account

“Vesting” means your right to receive the value of a specific part of your Plan account as a benefit from the Plan. Once you are vested in a portion of your Plan account, that portion may not be forfeited or taken from you. But please note that the value of the vested portion of your Plan account may go up or down, based on the value of the Plan’s investment funds you have chosen.

You are always 100% vested in any before-tax, Roth, or after-tax contributions that you make to the Plan, as well as in any matching contributions that your employer makes to the Plan on your behalf (and any investment earnings or losses attributable to those contributions).

You will become vested in any Company discretionary contributions in your Plan account—and the investment earnings or losses attributable to those discretionary contributions—over time, based on your “vesting service.” Specifically, if you complete 3 years of vesting service, you will become fully vested in any discretionary contributions.

Other vesting schedules applied to prior contribution types. For information about those schedules, please call the Principal Contact Center at 1-800-547-7754.

In addition to these schedules, you are automatically 100% vested in your Plan account if you remain employed by a Perdue Company on the date you:

- Reach age 65;
- Are considered totally and permanently disabled under a Perdue Company disability plan or Social Security; or
- Die.

Counting Your Vesting Service

You have a year of vesting service for each calendar year in which you are credited with at least 1,000 hours of service (see “Hour of Service”). In calculating your vested percentage, all service you perform for the Perdue Companies is generally counted. However, exceptions apply if you have a “break in service.” For vesting purposes, you have a break in service if you complete less than 501 hours of service during a calendar year. However, if you are absent from work for certain leaves of absence – such as maternity or paternity leave – you may be credited with up to 501 hours of service in order to prevent a break in service (see “Hour of Service”).

Returning to Employment After a Break in Service

If you have not made 401(k) deferrals and have no vesting (0% vested) in the Company discretionary contributions in your Plan account and have a break in service of five years or more, all the service you earned before the five-year break no longer counts for vesting purposes. So if you return to employment after a break in service of five years or more, you will be treated as a new associate (with no prior service) for purposes of determining your vesting service in the Plan.

If you have made 401(k) deferrals, or if you are vested in the Company discretionary contributions in your Plan account, and have a break in service, all your years of vesting service are restored when you return to employment.

The Plan Administrator monitors the break in service rules and can provide you with additional information on their effect.

How Vesting Affects Your Benefit

If your employment ends when you are less than 100% vested in the Company discretionary contributions in your Plan account, you forfeit the non-vested portion of those contributions (and associated investment returns). The Plan uses forfeitures to pay the Plan's expenses and administrative fees. If forfeitures remain after those fees are paid, the Plan uses remaining forfeitures to pay Company matching contributions or discretionary contributions for other participants.

If you return to employment after forfeiting any part of your Plan account, the amount you forfeited will be restored to your Plan account if:

- Your break in service is less than five years; *and*
- You repay any distribution you received from the Plan when your employment ended within five years from the date of your re-employment.

Receiving Money from the Plan While You Are Working

The purpose of the Plan is to help you save money for retirement years, but it includes features that allow you to receive money from your Plan account while you are still working for the Perdue Companies.

Plan Loans

You may borrow from the vested portion of your Plan account and use the money for any purpose. The Plan has a written loan policy that explains the rules governing Plan loans in detail; for a copy, call the Principal Contact Center at 1-800-547-7754.

Your Plan loan cannot be more than the lesser of:

- One-half of your vested Plan account at the time of the loan; and
- \$50,000, *minus* your highest outstanding Plan loan balance during the past 12 months.

The minimum loan allowed by the Plan is \$1,000. You may have only one Plan loan at a time. No more than two loan applications may be approved during any calendar year and a minimum of one month must pass between the dates that one loan is paid off and a new loan is applied for. A \$75 loan processing fee is charged for each loan from the Plan.

All Plan loans must be repaid within five years, with interest. You repay your loans by payroll deduction, but you may repay your loan in full, without penalty, with a cashier's check or money order made payable to Principal Trust Company, the Trustee.

Non-Hardship Withdrawals

You may withdraw certain funds from your Plan account if you meet the requirements set out by the Plan and/or the IRS. All or a portion of any withdrawal from your Plan account is taxable to you; see "Taxes on Your Plan Benefits" for details.

Tables in the Appendix of this SPD include short descriptions of current and prior plan accounts and the distribution options available for each account. For more information on which prior or current Plan contributions, if any, may be eligible for a non-hardship withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Age 59½ or Older

When you are age 59½ or older, you may withdraw money from the vested portion of these funds in your Plan account at any time, without proving a financial hardship:

- Your 401(k) deferrals (before-tax and Roth);
- Your rollover contributions;
- Company matching contributions; and
- Company discretionary contributions.

Taxes are withheld from your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

Tables in the Appendix of this SPD include short descriptions of current and prior plan accounts and the distribution options available for each account. For more information on which prior or

current Plan contributions, if any, may be eligible for an age 59½ (or older) withdrawal, please call the Principal Contact Center at 1-800-547-7754.

If You Are Younger than Age 59½

If you are not yet age 59½ and you do not have a financial hardship, you may withdraw only the following funds in your Plan account:

- After-tax **matched** contributions you made to the Plan more than two years ago;
- After-tax **unmatched** contributions you made to the Plan;
- After-tax rollover contributions you rolled over to this Plan; and
- Rollover contributions you rolled over to the Coleman Natural Foods, LLC 401(k) Plan prior to January 1, 2013.

Taxes are withheld from the taxable portion of your withdrawal unless it is directly rolled over to an eligible tax-deferred account.

Certain prior contribution types may also permit in-service withdrawal without a financial hardship; see the table in the Appendix of this SPD for details, or call the Principal Contact Center at 1-800-547-7754.

Hardship Withdrawals

You may make a hardship withdrawal of certain funds in your Plan account if you meet the requirements set out by the Plan and/or the IRS. Hardship withdrawals are allowed only when you need to pay:

- Medical expenses not covered by insurance, for you or your dependents;
- Costs directly related to the purchase of your home – but not for regular mortgage payments;
- College tuition, fees, and room and board expenses for you or your dependent for the next 12 months;
- Expenses to prevent your eviction or foreclosure on your home;
- Funeral or burial expenses for your parent, spouse or dependent;
- Expenses to repair uninsured damage to your home resulting from a natural disaster; or
- Expenses and losses (including loss of income) you incur due to a disaster declared by FEMA, if your principal residence or place of employment is located in an area designated by FEMA for individual assistance.

To qualify for a hardship withdrawal, you must show that you have first exhausted all other sources of funds to meet your need, including distributions (but not loans) from the Plan. You may withdraw only the amount needed to meet your financial need, including amounts you must pay in taxes and penalties on your withdrawal. The Plan Administrator requires documentation from a third party to justify your financial need.

Taxes are not required to be withheld from your hardship withdrawal, and it is not eligible for tax-deferred rollover.

Certain prior contribution types may also be eligible for a hardship withdrawal; see the tables in the Appendix of this SPD for details, or call the Principal Contact Center at 1-800-547-7754.

Receiving Your Benefit from the Plan

Because the Plan is designed to help fund your retirement, the Plan's benefits are payable when you reach age 65, the Plan's normal retirement age. But you may receive your benefit from the Plan before or after that date, depending on your personal circumstances.

The Plan pays benefits in a single lump sum. Also, you may take partial distributions of your account (subject to the Plan's administrative procedures).

To file a claim for benefits from the Plan, contact the Principal Contact Center at 1-800-547-7754. See the section "Claims" for more information.

When You Retire or Become Disabled

You may receive your Plan benefit when you retire at age 65 or older, or when you become totally and permanently disabled under the terms of a Perdue Company disability plan or Social Security. If you reach age 65 or incur a disability while you are employed by a Perdue Company, you are 100% vested in your Plan account, and the full amount is payable to you as your Plan benefit.

When Your Employment Ends

If your employment ends before you reach age 65 and you are not disabled, you may receive the vested portion of your Plan account as your Plan benefit. You forfeit any part of your Plan account in which you are not 100% vested.

When your employment ends, Principal sends you information about how to receive your Plan benefit. You will have the option of rolling over your Plan benefit to another tax-qualified plan, as described in "Rolling Over Your Benefit to Another Plan."

The value of your Plan account determines your options for receiving your Plan benefit.

Options for Deferring Your Benefit

If your employment ends and you wish to defer receiving your Plan benefit, you may do so until you reach your "required beginning date" (see below). Call the Principal Contact Center at 1-800-547-7754 for more information about the "required minimum distribution" rules.

When Your Plan Account Is More Than \$5,000

If the value of your Plan account (excluding any rollover contributions into the Plan) is more than \$5,000 when your employment ends, you may receive your Plan benefit at any time, but generally not later than your "required beginning date" which is the April 1st of the year following the later of the year in which you attain age 72 (age 70½ if you reached such age by December 31, 2019), or the year in which you terminate employment. At that time, you may take a lump sum distribution, or partial distributions, as long as they are sufficient to meet the "required minimum distribution" rules. You continue to direct the investment of your Plan account, using the same investment options offered to all other Plan participants.

When Your Plan Account Is Between \$1,000 and \$5,000

If the vested portion of your Plan account is more than \$1,000, but not more than \$5,000 (excluding any rollover contributions into the Plan) when your employment ends, you must receive your benefit from the Plan. Principal will send you information about your options for receiving your benefit from the Plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If you do not tell Principal how you want to receive your Plan benefit, your Plan benefit will be rolled over to an individual retirement account (IRA). The Plan Administrator has chosen the Total IRA program, offered by The Mid Atlantic Trust Company, as the automatic IRA to receive your rollover. Your rollover funds will be invested in a type of investment designed to preserve principal and provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund), unless you elect other investments.

All fees and expenses related to this rollover IRA and the IRA investments will be allocated solely to you, as the IRA holder. You may transfer the IRA to another IRA of your choosing.

For more information regarding the Plan's automatic rollover provisions, the IRA provider and fees and expenses attendant to the IRA, call the Principal Contact Center at 1-800-547-7754.

When Your Plan Account Is \$1,000 or Less

If the vested portion of your Plan account is \$1,000 or less when your employment ends, you must receive your benefit from the Plan. Principal will notify you of your right to roll over your Plan benefit to a rollover IRA or another tax-qualified plan. The Plan is required to withhold 20% of your benefit for federal income taxes, plus an additional amount for state taxes in certain states, unless you rollover your benefit to a rollover IRA or other tax-qualified plan.

If You Die

If you have a balance in your Plan account when you die, the Plan will pay it to your beneficiary (described in "Naming Your Beneficiary"). Your beneficiary may make periodic withdrawals, or defer receiving your Plan benefit, but no longer than shown here (if you die after December 31, 2019):

- **When your beneficiary is your spouse**, he or she may defer receiving your Plan benefit until the *later of*:
 - The end of the first complete calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules;
 - The end of the calendar year in which you would have reached age 72 (your "required distribution date"), with annual distributions in amounts that satisfy the required minimum distribution rules; or
 - The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is an "eligible designated beneficiary" other than your spouse**, the Plan benefit must begin by the later of:
 - December 31 of the calendar year after your death, with annual distributions in amounts that satisfy the required minimum distribution rules; or

- The end of the tenth calendar year following the calendar year of your death, with the account distributed in full by that time.
- **If your beneficiary is not an “eligible designated beneficiary”**, the Plan benefit must be distributed by the end of the tenth calendar year following the calendar year of your death.
- **An “eligible designated beneficiary”** is your surviving spouse, your child who has not reached the age of majority at your death, a chronically ill individual (as defined by the Internal Revenue Code), or any other individual who is not more than ten years younger than you.

Rolling Over Your Benefit to Another Plan

If your employment ends and you take a distribution of the vested portion of your Plan account, you have the option to roll over your Plan benefit to another tax-qualified plan, such as a Rollover IRA or another employer’s tax-qualified plan, such as a 401(k), 403(b), or a governmental 457(b) plan.

There are two ways to make a rollover from the Plan:

Indirect Rollover

When you receive a distribution from the Plan, you have 60 days to roll over that distribution to another tax-qualified plan. If you wait more than 60 days to complete your rollover, the full value of your distribution from the Plan becomes taxable to you.

The Plan is required to withhold 20% of the distribution of your Plan benefit for federal income taxes. (Additional state-level mandatory tax withholding may also apply.) In order to defer taxes on the full value of your Plan benefit, you must roll over 100% of your Plan benefit within the 60-day limit. This means you will have to use other funds with your rollover contribution to make up the 20% withheld for taxes, otherwise the 20% withheld will become taxable to you.

Direct Rollover

You may avoid tax withholding by electing a direct rollover of your account to another tax-qualified plan or account. With a direct rollover, your funds are transferred directly to the new plan or account, and you do not take possession of them.

Taxes on Your Plan Benefits

The Plan is a “tax-qualified plan” under IRS regulations. This means that much of the money in your Plan account (other than Roth and after-tax contributions)—including Company contributions and investment earnings—is sheltered from income taxes until you take it from the Plan (and is further sheltered if you do a direct rollover as discussed above). This section describes how taxes affect your benefits when you receive them from the Plan, according to tax laws in effect at the time this SPD was written.

Ordinary Income Taxes

Before-tax deferral contributions, Company contributions, and their investment earnings are subject to federal, state and local income taxes upon distribution. Roth deferral contributions are income tax-free upon distribution, and their investment earnings may potentially be income-tax free upon distribution, if IRS requirements are satisfied (and if permitted by state/local law). After-

tax contributions are tax-free upon distribution, but their investment earnings are taxable upon distribution. Taxation may be deferred through a rollover to another employer-sponsored retirement plan or an individual retirement account.

For distributions that are not directly rolled over, the Plan is required to withhold 20% of the taxable amount as federal income tax withholding. Additional state and local mandatory withholding may also apply.

Tax treatment and rollover rules are complex, vary based on contribution type and the type of account receiving the rollover, and are subject to change. You will receive additional information when you are ready to take a distribution, and should consult with a tax advisor for assistance.

Additional 10% Tax

If you receive a distribution from the Plan before you reach age 59½ – as a Plan benefit or as a hardship withdrawal – that distribution may be subject to an additional 10% federal tax for an “early distribution,” sometimes referred to as a “penalty tax,” if it is not rolled over. This additional 10% tax does not apply, however, if your distribution is:

- Paid due to your disability;
- Paid as a series of equal payments over your life or life expectancy (or your and your beneficiary’s lives or life expectancies);
- Used to pay certain tax-deductible medical expenses;
- Paid directly to the government to satisfy a federal tax levy;
- Paid to you during a period of at least 180 days of active military duty; or
- Paid to an “alternate payee” under a Qualified Domestic Relations Order (see “Receiving a Qualified Domestic Relations Order”).

More information about the additional 10% federal tax is found on IRS Form 5329.

You will receive a more comprehensive notice describing tax issues when you are electing your distribution.

Events That May Affect Your Benefit

This section outlines events that may affect your benefit from the Plan.

Military Leave of Absence

Generally, if you return to active employment with a Perdue Company after a period of military service of less than five years, your period of military service will count toward your vesting service, so long as you return to work within the time provided by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Beginning with your return to active work with a Perdue Company, you have a period equal to five years (or, if shorter, three times your period of military service) to make up the contributions you could have made to the Plan during that time. Your compensation for the period of your military service is assumed to be the amount you would have received from the Participating Companies if you had remained an active associate during your period of military service.

If you make up your 401(k) deferrals, your employer will make Company matching contributions equal to the amount you would have received if you worked during your military leave. You are not, however, credited with past investment earnings for those made-up contributions.

Your employer will also make up any Company discretionary contributions you would have received if you had remained an active associate during the period of your military service.

Contributing to Another Tax-Qualified Plan in the Same Year

Your before-tax and Roth contributions (combined) to tax-qualified plans are limited to a dollar amount each calendar year (see “Your Before-Tax 401(k) Deferrals”). Your 401(k) deferrals count toward this annual limit, as well as any before-tax or Roth contributions you make to another employer’s 401(k) plan, Section 408(k) simplified employer pension plan, Section 403(b) annuity contract, or elective employer contributions under Section 408(p)(2)(A)(i) of the Internal Revenue Code.

If you have contributed to another employer’s tax-qualified plan during the same year you make 401(k) deferrals to this Plan, you may need to reduce your 401(k) deferrals so that you do not exceed the limit.

You have until March 1 of the following year to notify your former employer or Principal to request a refund of excess contributions. The excess amount, plus any investment gain or loss, will be issued to you no later than April 15. For more information, call the Principal Contact Center at 1-800-547-7754.

Receiving a Qualified Domestic Relations Order

A Qualified Domestic Relations Order (or “QDRO”) is a court order that provides child support, alimony or marital property rights to a spouse, former spouse or dependent from your Plan account. A QDRO must be issued pursuant to a state domestic relations law and must meet certain technical requirements. A QDRO cannot require the Plan to provide any type or form of payment, or any option, not permitted by the Plan (although it can require payment before you terminate employment).

Under a QDRO, a former spouse may be entitled to the same rights as a current spouse, with respect to some or all of your account. If this is the case, then any provisions in the Plan that require spousal approval, such as naming a nonspouse beneficiary or (if applicable) choosing certain optional forms of payment, may apply to your former spouse with respect to the portion of your account designated for the former spouse (see “Naming Your Beneficiary”).

The Plan Administrator will determine whether an order meets the requirements of a QDRO. While the Plan Administrator is making this determination, you may be prohibited from receiving a distribution from the Plan.

If it appears that you may be subject to a QDRO, you should call the Corporate Benefits Line at 1-800-997-3247. You can obtain, without charge, a copy of the Plan’s QDRO procedures. Your account may be charged a \$600 fee for processing the QDRO, and this fee will be charged before your account is divided and the order is implemented. Information about the fee will be included in the Plan’s QDRO procedures.

If the Plan Fails Non-Discrimination Testing

Federal law requires the Plan to pass certain non-discrimination tests each year. These tests are done to ensure the Plan does not discriminate in favor of highly compensated associates.

If the Plan fails these tests, it may have to refund contributions to some highly compensated associates. If these rules affect you, you will be notified.

If the Plan Terminates

If the Plan terminates, your Plan benefit will become fully vested, and the assets of the Plan will be used solely to provide benefits to you, other Plan participants and designated beneficiaries after any expenses of the Plan have been paid. Your benefits will be paid to you as soon as practical. After all assets have been distributed, the Trustee has no more responsibilities under the Plan, and neither you nor your beneficiary will have any further claim to the Plan.

Loss of Benefits

You may lose benefits from the Plan if you terminate employment before earning enough years of vesting service to become 100% vested in your Plan account. You may also lose benefits due to poor investment experience, the application of IRS limits, the imposition of taxes or penalties on your benefits, or the application of a QDRO.

Claims

The Plan Administrator has established these procedures for filing claims for benefits available under the Plan. ***Failure to follow these procedures within the required time periods will result in the loss of your right to sue in court.***

When a claim exists, you, your beneficiary or an authorized representative may call the Principal Contact Center at 1-800-547-7754, or access the Principal website online at www.principal.com to start the claims process. The Plan Administrator will respond to the claim in writing within 90 days of the submission, stating whether you are eligible for benefits under the Plan. If the Plan Administrator determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator may extend this response period by up to 90 days and will notify you of the special circumstances and the date by which a decision is expected to be made.

Decisions on Claims

You will receive a decision on your claim in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan Administrator's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination; and
- Demonstrate compliance with the Plan Administrator's processes or safeguards.

Appealing a Claim

The Plan wants to be sure that you and your beneficiaries receive the full benefits for which you are eligible under the Plan.

If an initial claim for benefits under the Plan is denied, in whole or in part, in a letter from a Claims Administrator or otherwise, you have 60 days to appeal the denial. Your appeal must be in writing and should contain the reasons why you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits. Within 60 days after receiving your appeal, the Plan Administrator will give you (and your counsel, if any) an opportunity to present your position to the Plan Administrator in writing, and an opportunity to review any pertinent documents.

The Plan Administrator will notify you of its decision in writing within the 60-day period, stating specifically the basis of the decision and the specific provisions of the Plan on which the decision is based. If because of special circumstances requiring additional time to make a decision the 60-

day period is not sufficient, the decision may be deferred for up to another 60 days at the election of the Plan Administrator, and you will be notified of the delay.

If your claim is denied on appeal, you will receive written notice of the Plan Administrator's final decision on your claim, which contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A statement that you may request, free of charge, reasonable access to and copies of all relevant documents, records and information; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA.

You must exhaust all of the procedures described above before pursuing the claim in any other proceeding.

You cannot file a civil action pursuant to ERISA Section 502(a)(1)(B), with respect to a benefit under the Plan, more than two years after your appeal is denied (or deemed denied).

Any civil action to obtain a benefit under ERISA Section 502(a)(1)(B) must be filed in the United States District Court for the District of Maryland, and the law as stated and applied by the United States Court of Appeals for the Fourth Circuit or the United States District Court for the District of Maryland will govern.

Any claim under ERISA or otherwise with respect to the Plan (other than a claim for benefits under ERISA Section 502(a)(1)(B)) shall be submitted to binding arbitration, on an individual (non-class) basis, within two years after the claim arises (or within such shorter period otherwise applicable to the claim).

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You will receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You will receive a quarterly statement setting forth your Plan account balances and the extent to which you are vested in such account balances.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

Your assets pay investment management fees, which are disclosed in the applicable prospectus for each investment fund. You also pay for routine administrative costs, as well as special fees (such as for processing QDROs). A fee disclosure document will be provided each year.

Funds in the Plan are held in trust for participants and their beneficiaries. The Trustee pays all benefits under the Plan from available assets in the trust. Contributions from participants and Participating Companies go into a trust fund managed under the terms of a trust agreement with the Plan's Trustee.

The Plan Is Not Insured

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), a corporation was established to insure the benefits promised under certain types of pension plans. The corporation is known as the Pension Benefit Guaranty Corporation ("PBGC").

Under present law, the PBGC cannot insure the benefits under this Plan because it is a profit sharing plan in which the benefits you receive are based on your actual account balances. The PBGC insures only "defined benefit pension" plans.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Perdue Companies and any associate. As an "at-will employee," either your employer or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Document Governs

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the plan document that determines your rights and the rights of your dependents under the Plan. In the event of a discrepancy between this summary plan description and the plan document, the plan document will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon any Perdue Company or which alters the Plan or other documents maintained in conjunction with the Plan.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment, to the extent permitted by applicable law.

Assignment of Benefits

Neither you nor your beneficiary may assign your benefits under the Plan. Generally, the Plan and its benefits may not be seized to pay your debts or obligations unless you elect a withdrawal

from your Plan account. However, the Plan is required to honor a QDRO, described in the section “Receiving a Qualified Domestic Relations Order,” which will reduce the Plan benefit payable to you.

Plan May Be Amended or Terminated

The Plan Sponsor expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time, subject to the terms of the plan document. In addition, the Plan Sponsor does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator

The Plan Administrator has the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan shall be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Appendix

Table of Current Plan Accounts

401(k) Money Types	Account Description	Loans Available?	In-Service Withdrawal Available?	Hardship Withdrawal Available?
401(k)	Your own <i>before-tax</i> contributions to the Plan	Yes	Age 59½	Yes
Roth 401k	Your own <i>Roth</i> contributions to the Plan	Yes	Age 59½	Yes
Voluntary Unmatched	Your own <i>after-tax</i> contributions that <i>were not</i> eligible for a Company match	Yes	Any age	N/A
Safe Harbor Match	Matching contributions made by the Participating Companies since January 1, 2000	Yes	Age 59½	Yes
Rollover	Before-tax amounts that you may have received from another employer's retirement plan or an IRA, and chose to transfer to this Plan	Yes	Age 59½	Yes
After-tax Rollover	After-tax amounts that you may have received from another employer's retirement plan, and chose to transfer to this Plan	Yes	Any age	N/A
Catch-Up	Your own additional before-tax contributions to the Plan if age 50 or older (over and above the regular limits)	Yes	Age 59½	Yes
Discretionary Contribution	Additional contributions that the Participating Companies may make, once a year, based on its profitability	Yes	Age 59½	No

Table of Prior Plan Accounts

401(k) Money Types	Account Description	Loans Available?	In-Service Withdrawal Available?	Hardship Withdrawal Available?
CNF Plan Rollover	Any rollover contributions that you made to the Coleman Natural Foods, LLC 401(k) Plan, which was merged into this Plan effective January 1, 2013	Yes	Any age	N/A

Savings Plan Identification

Plan Name	The official Plan name is The Perdue Savings Plan.
Plan Sponsor	The Plan Sponsor is Perdue Farms Inc.
Type of Administration	The Plan is administered by Principal.
Plan Administrator	The Perdue Farms Inc. Investment Committee 31149 Old Ocean City Road Salisbury, MD 21804 410-543-3000
Trustee	The Plan's Trustee is: Delaware Charter Guarantee & Trust Company d/b/a Principal Trust Company 1013 Centre Road, Suite 300 Wilmington, DE 19805-1265
Collective Bargaining Agreements	The terms of this Plan, as set forth in this SPD, apply to employees entitled to participate in the Plan under the terms of the collective bargaining agreements with the following: <ul style="list-style-type: none"> • United Food and Commercial Workers Union, Local No. 21, Production Group • United Food and Commercial Workers Union, Local No. 21, Distribution Group
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator or the Plan Trustee.
Plan Records and Plan Year	The Perdue Savings Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Savings Plan is considered a defined-contribution retirement plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Effective Date	The original effective date of the Plan is December 1, 1955. This SPD is effective as of July 1, 2021.
Plan Number	The Plan Number is 001.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

IRS Annual Dollar Limits

For 2021

Annual Compensation Limit	\$290,000
Annual Contribution Limit	\$58,000
Annual Deferral Limit	\$19,500
Annual Catch-Up Deferral Limit	\$6,500
Highly Compensated Employee	\$130,000 paid in 2020
Adjusted Gross Income Limits For Tax Credits	\$66,000 for married filing jointly \$49,500 for head of household \$33,000 for single or married filing separately

Matching Contribution Examples

If you are eligible for the match from the first day of the Plan Year:

Example: Ms. Jones has satisfied the year of service requirement and is eligible for matching contributions as of January 1, 2021. Her eligible compensation is \$2,500 per bi-weekly pay period. For each of the first four pay periods in 2021, she contributes before-tax 4% of eligible compensation (\$100 per pay, \$400 total), and receives total matching contributions of \$400. For the fifth pay period in 2021, she contributes before-tax 12% of eligible compensation (\$300). Her matching contribution for the fifth pay period is \$225, which is calculated as follows:

Total before-tax contributions for 2021 (year-to-date, including the fifth pay period): \$700

Total eligible compensation for 2021 (year-to-date, including the fifth pay period): \$12,500

5% of total eligible compensation for 2021 (year-to-date, including the fifth pay period): \$625

Match for the fifth pay period: \$225, which is \$625 (the lesser of year-to-date before-tax contributions or 5% of year-to-date eligible compensation), minus the \$400 of match already received for 2021

If you become eligible for the match during the Plan Year:

Example: Ms. Smith receives eligible compensation of \$12,000 for each of the 26 bi-weekly pay periods during 2021. She satisfies the year of service requirement and becomes eligible for matching contributions as of the sixth payroll period in 2021. She is under age 50 and not eligible for catch-up contributions, so her annual before-tax contribution limit for 2021 is \$19,500.

For the first five payroll periods in 2021, she has contributed before-tax 12% of her pay (\$1,440 per pay, or \$7,200), and receives no matching contributions because she is not yet eligible. After becoming eligible (beginning with the sixth pay period in 2021), she continues to contribute at a rate of 12% (\$1,440 per pay), and receives matching contributions of \$600 per pay. She reaches the IRS limit on before-tax contributions (\$19,500 for 2021) on the 14th pay period, and can no longer make before-tax contributions for 2021. At that point, she has received matching contributions of \$5,400 (she has been matched for nine pay periods), and cannot receive further matching contributions in 2021 because she can no longer contribute.

Ms. Smith could have maximized her 2021 matching contributions by taking the following steps:

1. Calculating the maximum available match for 2021, by multiplying the 5% match rate by her eligible compensation payable on or after she becomes eligible for the match ($5\% \times \$252,000$ (which is \$12,000 for 21 pay periods)), yielding a maximum available 2021 match of \$12,600. (Had her compensation payable after

she becomes eligible for the match exceeded the 2021 IRS limit of \$290,000, her maximum 2021 match would have been \$14,500.)

2. Ensuring that she is able to contribute at least \$12,600 for 2021 after she becomes eligible for the match, by limiting her 2021 before-tax contributions before she is eligible for the match to \$6,900 (i.e., \$19,500 – \$12,600).

3. Setting her before-tax contribution rate, following her match eligibility date, at a rate that will enable her to contribute for all of the remaining pay periods in 2021, and not reach the maximum before the end of 2021. A 5% before-tax election will yield this result (i.e., \$12,600 divided by 21 payroll periods will allow her to contribute \$600 for each of the 21 payroll periods, and receive the maximum available \$600 match each pay period).

In each of the above examples, any portion of the participant's before-tax contributions could be substituted with Roth contributions.

THE PERDUE SAVINGS PLAN
(PLAN NUMBER 001)
AMENDED AND RESTATED
EFFECTIVE JANUARY 1, 2014

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THE PERDUE SAVINGS PLAN

WHEREAS, A.W. Perdue & Son, Inc. established the Perdue Savings Plan (the "Plan"), effective December 1, 1955, for certain of its employees; and

WHEREAS, A.W. Perdue & Son, Inc. has been succeeded in interest due to various transactions and reorganizations; and

WHEREAS, the current successor in interest to A.W. Perdue & Son, Inc., Perdue Farms Inc. (the "Company"), has amended the Plan from time to time; and

WHEREAS, effective as of January 1, 2013, Coleman Natural Foods, LLC, Draper Valley Holdings, LLC and certain of their affiliated companies became Participating Companies in the Plan; and

WHEREAS, effective as of January 1, 2013, the Coleman Natural Foods, LLC 401(k) Plan, the Draper Valley Holdings, LLC Non-Union Retirement Plan, and the Draper Valley Holdings, LLC 401(k) Plan for UFCW Local No. 44 Members were amended, restated and merged into the Plan; and

WHEREAS, the Plan is intended to qualify as a profit-sharing plan, with a cash-or-deferred feature that qualifies under Sections 401(a) and 501(a) of the Code and that complies with the provisions of ERISA; and

WHEREAS, the Company desires at this time to amend and restate the Plan again, generally effective as of January 1, 2014, for the purpose of making required good faith interim and discretionary amendments in accordance with (i) IRS Revenue Procedures 2007-44; (ii) the "2012 Cumulative List of Changes in Plan Qualification Requirements" issued in IRS Notice 2012-76; and (iii) such other statutory or regulatory guidance as might be applicable, all as updated, revised or amended from time to time; provided, however, that the rights, benefits and interests of any person who was covered by the Plan in effect before January 1, 2014 and whose death, Total Disability, or Severance from Employment occurred before January 1, 2014 shall, unless otherwise required by law or by the Plan, be determined under the provisions of the Plan as in effect on the date of such person's death, Total Disability or Severance from Employment.

NOW, THEREFORE, effective January 1, 2014 (except as otherwise set forth herein), the Plan is continued, amended, and restated as hereinafter set forth:

ARTICLE I
DEFINITIONS

Except where otherwise clearly indicated by context, the masculine shall include the feminine and the singular shall include the plural, and vice versa. Any term used herein without an initial capital letter that is used in a provision of the Code with which this Plan must comply to meet the requirements of Section 401(a) of the Code shall be interpreted as having the meaning used in such provision of the Code, if necessary for the Plan to comply with such provision.

“Account” means the entries maintained in the records of the Trustee which represent the Participant’s interest in the Fund. The term “Account” shall refer, as the context indicates, to any or all of the following:

- “1% Company Contribution Account” means the Account to which are credited 1% Company Contributions allocated to a Participant prior to January 1, 2009, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “50% Company Match Account” means the Account to which are credited matching contributions allocated prior to January 1, 2000 for participants employed at Petersburg, West Virginia, Monterey, Tennessee, or Brentwood, Tennessee, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “401(k) Account” means the Account to which are credited Salary Reduction Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto. This Account may be divided into two sub-accounts, which shall be “Sub-account A” and “Sub-account B.” Sub-account A shall consist of all earnings allocable to Salary Reduction Contributions as of November 30, 1988, and all Salary Reduction Contributions. Sub-account B shall consist of all earnings on the amount in Sub-account A that accrue after November 30, 1988. Any losses posted after November 30, 1988 shall be charged first against Sub-account B.
- “After-Tax Rollover Account” means the Account to which are credited After-Tax Rollover Contributions made by a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Catch-Up Account” means the Account to which are credited Catch-Up Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.

- “Company Basic Account” means the Account to which are credited Company Basic Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Company Match Account” means the Account to which are credited Matching Contributions allocated to a Participant prior to January 1, 2000, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Company Prior Match Account” means the Account to which are credited Prior Matching Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Discretionary Contribution Account” means the Account to which are credited Discretionary Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Employee Prior Account” means the Account to which are credited Employee Prior Plan Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Former MPP Account” means the Account to which are credited Company contributions that were made to a separate account for a participant in the Perdue Supplemental Retirement Plan (which account was transferred to this Plan pursuant to the merger of the Perdue Supplemental Retirement Plan with and into this Plan), as adjusted for distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Old Plan Account” means the Account to which are credited Company contributions that were made prior to April 1, 1970, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Prior Plan Rollover Account” means the Account to which are credited any rollover contributions that a participant made to the FFM Retirement Saving and Investment Plan (Gol-Pak, Monterey), and which were later transferred to this Plan, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Qualified Non-Elective Contribution Account” means the Account to which are credited qualified non-elective contributions that were made to the Plan as part of corrective contributions

allocated to a Participant, pursuant to the Employee Plans Compliance Resolution System, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.

- “Rollover Account” means the Account to which are credited a Participant’s Rollover Contributions, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Safe Harbor Match Account” means the Account to which are credited Safe Harbor Matching Contributions, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Voluntary Matched Account” means the Account to which are credited Voluntary Matched Contributions allocated to a Participant prior to January 1, 2010, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.
- “Voluntary Unmatched Account” means the Account to which are credited Voluntary Unmatched Contributions allocated to a Participant, as adjusted for withdrawals and distributions therefrom, and the earnings, losses and expenses attributable thereto.

“Affiliated Company” means, with respect to any Participating Company, (a) any corporation that is a member of a controlled group of corporations, as determined under Section 414(b) of the Code, which includes such Participating Company; (b) any member of an affiliated service group, as determined under Section 414(m) of the Code, of which such Participating Company is a member; (c) any trade or business (whether or not incorporated) that is under common control with such Participating Company, as determined under Section 414(c) of the Code; and (d) any other organization or entity which is required to be aggregated with the Participating Company under Section 414(o) of the Code and regulations issued thereunder.

“Annual Additions” means the sum of those amounts allocated to a Participant’s Account under this Plan and under any other qualified defined contribution plan to which a Participating Company or an Affiliated Company contributes for any Limitation Year, consisting of (a) Company contributions, (b) Employee contributions, and (c) forfeitures. In addition to the forgoing, Annual Additions shall also include (a) any amounts allocated to such Participant’s individual medical account, as defined in Section 415(l)(1) of the Code, which is part of a defined benefit plan maintained by a Participating Company or an Affiliated Company; (b) any contributions that are attributable to post-retirement medical benefits allocated to the separate account of such Participant (if he is a key employee, as defined in Section 419A(d)(3) of the Code) under a welfare benefit fund, as defined in Section 419(e) of the Code, maintained by a Participating Company or an Affiliated Company; (c) mandatory employee contributions to a defined benefit plan maintained by the Company or an Affiliated Company; and (d)

amounts that are treated as annual additions under an annuity contract described in Section 403(b) of the Code. However, "Annual Additions" shall exclude (a) rollover contributions; (b) any repayments that a Participant makes on a loan issued to such Participant; (c) amounts reallocated to a Participant under a Qualified Domestic Relations Order; (d) the restoration of a Participant's accrued benefit by the Company, in accordance with Section 411(a)(3)(D) of the Code or Section 411(a)(7)(C) of the Code; (e) any Catch-Up Contributions made under Section 3.1(c) of the Plan; (f) excess deferrals that are distributed in accordance with Section 1.402(g)-1(e)(2) or (3) of the Treasury regulations; (g) certain repayments of amounts described in Section 411(a)(7) of the Code; (h) employee contributions to a qualified cost-of-living arrangement within the meaning of Section 415(k)(2)(B) of the Code; and (i) any restorative payment that is allocated to an Account. For these purposes, a "restorative payment" is a payment made to restore losses to the Plan resulting from actions (or inactions) by a fiduciary for which there is a reasonable risk of liability for breach of fiduciary duty under Title I of ERISA, or under other applicable federal or state law, where Participants who are similarly situated or treated similarly with respect to such payments. Payments made to the Plan to make up losses due to market fluctuations and other payments that are not made on account of a reasonable risk of liability for breach of fiduciary duty under Title I of ERISA are not restorative payments and will generally constitute contributions that shall be included as Annual Additions.

"After-Tax Rollover Contributions" means, for any Participant, that portion (if any) of a Participant's Rollover Contributions under Section 8.1 that reflect the Participant's after-tax contributions to the qualified plan(s) of his former employer(s).

"Age" means, for any individual, his age on his last birthday, except that an individual attains Age 59½ or Age 70½ on the corresponding date in the sixth calendar month following the month in which his 59th or 70th (respectively) birthday falls (or the last day of such sixth month if there is no such corresponding date therein).

"Alternate Payee" means any Spouse, former Spouse, child or other dependent of a Participant who is recognized by a domestic relations order (within the meaning of Section 414(p)(1)(B) of the Code) as having a right to receive all, or a portion of, the benefits payable under the Plan with respect to such Participant.

"Applied Forfeiture" means, with respect to each of a Participating Company's Matching Contributions, 1% Company Contributions, or Discretionary Contributions for a Payroll Period or Plan Year (as applicable), that portion of the total available forfeitures under Subsection 6.5(a) that the Committee directs be applied to offset such category of future contributions or offset Plan expenses and fees.

"Average Contribution Percentage" means, for a specified group of Eligible Employees for a Plan Year, the average of the Contribution Percentages for such Eligible Employees for the Plan Year.

"Average Deferral Percentage" means, for a specified group of Eligible Employees for a Plan Year, the average of the Deferral Percentages for such Eligible Employees for the Plan Year.

"Bargaining Unit Member" means a Covered Employee who is a member of one of the collective bargaining units listed in Appendix B to the Plan.

"Benefit Commencement Date" means, for any Participant or beneficiary, the date as of which the first benefit payment, including a single sum, from the Participant's Account is due, other than pursuant to a withdrawal under Article IX.

"Board of Directors" means the board of directors (or other governing body) of the Company, or its delegate.

"Break in Service" means, for any Employee, any calendar year described in Section 6.3.

"Catch-Up Contributions" means a Participant's elective deferrals as provided in Subsection 3.1(c).

"Code" means the Internal Revenue Code of 1986, as amended, and any regulations issued thereunder.

"Committee" means the individuals appointed by the Board of Directors (if any) or by the Company to supervise the administration of the Plan, as provided in Article XIV.

"Company" means Perdue Farms Inc., a Maryland corporation, and its successors.

"1% Company Contributions" means the amounts contributed by the Company prior to December 31, 2008, which have been credited to Participants' 1% Company Contribution Accounts.

"Company Basic Contributions" means the amounts contributed by the Company prior to June 30, 2000, which have been credited to Participants' Company Basic Accounts.

"Compensation" means, for any Eligible Employee, for any Plan Year or Limitation Year, as the case may be:

(a) For purposes of Sections 3.1, 3.4, and 3.5, subject to the limitations set forth in Subsection (c) of this definition, his total wages as reported in the box titled "Wages, tips, other compensation" of Form W-2 (i.e., wages as defined in Section 3401(a) of the Code and all other payments of compensation for which the Participating Company is required to furnish the employee a written statement under Sections 6041(d) and 6051(a)(3) of the Code) from a Participating Company for such Plan Year, reduced by reimbursements or other expense allowances, fringe benefits (cash and noncash), moving expenses, deferred compensation, and welfare benefits, but including Salary Reduction Contributions and elective contributions that are not includible in gross income under Section 125, 132(f)(4), 402(e)(3), 402(h) or 403(b) of the Code.

(b) For all other purposes, subject to the limitations set forth in Subsection (c) of this definition, the Employee's total wages as reported in the box titled "Wages, tips, other compensation" of Form W-2 (i.e., wages as defined in Section 3401(a) of the Code and all other payments of compensation for which the

Participating Company is required to furnish the Employee a written statement under Sections 6041(d) and 6051(a)(3) of the Code) plus:

- (1) Salary Reduction Contributions, and
- (2) Other amounts excluded from gross income under Section 125, 132(f)(4), 402(e)(3), 402(h) or 403(b) of the Code.

(c) With respect to any Plan Year, only compensation not in excess of the limit set forth in Section 401(a)(17) of the Code (as indexed) shall be taken into account for purposes of Subsection (a) (with the exception of Salary Reduction Contributions) and Subsection (b) of this definition.

(d) Amounts otherwise includable as Compensation shall only be taken into account on behalf of an Employee if the Employee is a Participant at the time amounts are paid.

(e) For purposes of determining Highly Compensated Employee status, the limitations on annual additions as described in Section 3.8, and the top-heavy provisions as described in Article XI (the "Statutory Purposes"):

(1) As permitted by Section 1.415(c)-2(d)(4) of the Treasury regulations, Compensation shall mean Compensation as defined in paragraph (b) of this definition, subject to paragraphs (2) and (3) below.

(2) Except to the extent required by Section 1.415(c)-2 of the Treasury regulations, Compensation shall include only Compensation paid during the Limitation Year and prior to a Participant's Severance from Employment. Consequently, (a) payments of regular compensation for services during the Participant's regular working hours, or compensation for services outside the Participant's working hours (such as overtime or shift differential), commissions, bonuses or other similar payments (but only if such payments would have been paid to the Participant prior to his Severance from Employment if he had continued in employment with a Participating Company), (b) payments for unused, accrued, bona fide sick, vacation or other leave (but only if the Participant would have been able to use the leave if employment had continued), or (c) payments received by the Participant pursuant to a nonqualified deferred compensation plan (but only if the payment would have been paid to the Participant at the same time if the Participant's employment had continued, and only to the extent that the payment is includable in the Participant's gross income), that would have been paid to the Participant prior to a Severance from Employment if the Participant had continued in employment with the Employer, and which are paid by the later of 2-1/2 months after Severance from Employment or the end of the Limitation Year that includes the date of Severance from Employment, shall be taken into account as Compensation for the Statutory Purposes. Other Compensation paid after the Limitation Year or after the Participant's Severance from Employment shall not be taken into account for Statutory Purposes.

(3) Compensation shall be determined without regard to whether the Employee was a Participant at the time the Compensation was paid and shall include amounts paid by an Affiliated Company that is not a Participating Company,

which would be compensation if such Affiliated Company were a Participating Company.

(f) For purposes of this definition, amounts under Section 125 of the Code include any amounts not available to a Participant in cash in lieu of health coverage because the Participant is unable to certify that he or she has other health coverage. An amount will be treated as an amount under Section 125 of the Code only if the Participating Company does not request or collect information regarding the Participant's other health coverage as part of the enrollment process for the health plan.

(g) Notwithstanding anything contained herein to the contrary, for Plan Years beginning on or after January 1, 2009, Compensation includes Differential Wage Payments, if applicable, to an Employee who does not currently perform services for the Company by reason of Qualified Military Service to the extent those payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the Company rather than entering Qualified Military Service. Further, the Plan will not be treated as failing to meet the requirements of any provision described in Section 414(u)(1)(C) of the Code by reason of any contribution or benefit that is based on such Differential Wage Payments, but only if all Employees of the Company performing Qualified Military Service are entitled to receive Differential Wage Payments on reasonably equivalent terms and, if eligible to participate in a retirement plan maintained by the Company, are eligible to make contributions based on payments on reasonably equivalent terms. "Differential Wage Payment" shall mean any payment which is made by the Company to an individual with respect to any period during which the individual is performing services in the uniformed services while on active duty for a period of more than 30 days, and which represents all or a portion of the wages the individual would have received from the Company if the individual were performing services for the Company, all within the meaning of Section 3401(h)(2) of the Code.

"Contribution Percentage" means, for any Eligible Employee for a given Plan Year, the ratio of:

- (a) the sum of:
 - (1) such Eligible Employee's Voluntary Contributions for the Plan Year; plus
 - (2) at the election of the Committee, such Eligible Employee's Safe Harbor Matching Contributions for the Plan Year; plus
 - (3) in the case of any Highly Compensated Eligible Employee, any employee contributions and employer matching contributions, including any elective deferrals recharacterized as employee contributions, under any other qualified retirement plan, or a tax credit employee stock ownership plan as defined in Section 409(a) of the Code, maintained by the Participating Company or any Affiliated Company; to
- (b) the Eligible Employee's Compensation for the Plan Year.

"Controlled Group" means a group consisting of all Participating Companies and any Affiliated Companies.

"Covered Employee" means each person who is classified by a Participating Company as a common law employee of such Participating Company, and who:

(a) is employed by a Participating Company on a regular basis (i.e., is not classified by the Participating Company as a contract worker or a temporary employee);

(b) is classified by the Participating Company as a member of Benefit Group 1, 2, 3 or 4;

(c) is not covered by a collective bargaining agreement, unless such agreement specifically provides for participation hereunder;

(d) is not a non-resident alien with no United States source income; and

(e) does not perform services for a Participating Company pursuant to an agreement with an employee leasing organization.

An individual who is not classified by a Participating Company as a common law employee shall not be a Covered Employee regardless of whether (1) the individual is considered an Employee by reason of being a leased employee (whether or not a Leased Employee as defined in this Article I), (2) the individual is classified by a Participating Company as an independent contractor, or (3) for employment tax or other purposes, the individual is subsequently determined to be a common law employee, or not to be a leased employee or independent contractor. For purposes of determining eligibility under the Plan, the classification to which an individual is assigned by a Participating Company shall be final and conclusive, regardless of whether a court, a governmental agency or any entity subsequently finds that such individual should have been assigned to a different classification.

"Deferral Percentage" means, for any Eligible Employee for a given Plan Year, the ratio of:

(a) the sum of:

(1) such Eligible Employee's Salary Reduction Contributions for the Plan Year; plus

(2) in the case of any Highly Compensated Eligible Employee, any Salary Reduction Contributions under any other qualified retirement plan, or a tax credit employee stock ownership plan as defined in Section 409(a) of the Code, maintained by the Participating Company or any Affiliated Company; to

(b) the Eligible Employee's Compensation for the Plan Year.

"Discretionary Contributions" means the amounts contributed by the Company pursuant to Section 3.5.

"Effective Date" means January 1, 2014, the effective date of this amended and restated Plan, or such other date as is specified herein; provided, however, that any provision which is contained in this amended and restated Plan (as the same may be further amended from time to time) and which is required to be effective before or

after January 1, 2014, in order to retain the qualification of the Plan under Section 401(a) of the Code shall, nevertheless, be effective as of its required effective date under the Code.

"Eligible Employee" means an Employee who has become an Eligible Employee as set forth in Section 2.3, and who has remained a Covered Employee at all times thereafter.

"Employee" means an individual who is employed by a Participating Company or an Affiliated Company. An individual who is not otherwise employed by a Participating Company or Affiliated Company shall be deemed to be employed by such Company if he is a Leased Employee with respect to whose services such Participating Company or Affiliated Company is the recipient, except as otherwise provided in the definition of "Leased Employee" contained herein.

"Employee Prior Plan Contributions" means a Participant's voluntary after-tax savings which were allocated to the Plan prior to January 1, 1987 and which have been credited to such Participant's Employee Prior Account.

"Employment Commencement Date" means, for any Employee, the date on which he is first entitled to be credited with an "Hour of Service" described in Paragraph (a)(1) of the definition of Hour of Service in this Article.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and any regulations issued thereunder.

"Former PACMA Employee" means an individual who was employed by PACMA immediately prior to July 30, 2004, and who became an Employee immediately thereafter.

"Former MPP Contributions" means, for any Participant, the contributions (if any) that were made by the Company on his behalf under the Perdue Supplemental Retirement Plan and that are credited to such Participant's Former MPP Account.

"Full Participant" means a Covered Employee who has satisfied the requirements to become a Full Participant as described in Section 2.4, and who has not thereafter ceased to be a Covered Employee.

"Fund" means the fund established for this Plan, administered under the Trust Agreement, out of which benefits payable under this Plan shall be paid.

"Highly Compensated Employee" means an Employee who:

(a) is a five-percent owner, as defined in Section 416(i) of the Code, either for the current Plan Year or the immediately preceding Plan Year; or

(b) received more than the dollar limit on Compensation set forth in Section 414(q)(1)(B) of the Code (as adjusted in accordance therewith) from a Participating Company or an Affiliated Company in the immediately preceding Plan Year.

"Hour of Service" means, for any Employee, a credit awarded with respect to:

(a) except as provided in (b) or (c),

(1) each hour for which he is directly or indirectly paid or entitled to payment by a Participating Company or an Affiliated Company for the performance of employment duties; or

(2) each hour for which he is entitled, either by award or agreement, to back pay from a Participating Company or an Affiliated Company, irrespective of mitigation of damages; or

(3) each hour for which he is directly or indirectly paid or entitled to payment by a Participating Company or an Affiliated Company on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), jury duty, layoff, leave of absence, or military duty; or

(4) each hour credited pursuant to Section 6.3.

(b) For any period that includes any hours for which an Hour of Service would otherwise be credited to an Employee under (a), above, the Committee may, in accordance with rules applied in a uniform and non-discriminatory manner, elect instead to credit Hours of Service using one or more of the following equivalencies:

<u>Basis Upon Which Records Are Maintained</u>	<u>Credit Granted to Individual For Period</u>
shift	actual hours for full shift
day	10 Hours of Service
week	45 Hours of Service
semi-monthly period	95 Hours of Service
month	190 Hours of Service

(c) Anything to the contrary in Subsection (a) or (b) notwithstanding:

(1) No Hours of Service shall be credited to an Employee for any period merely because, during such period, payments are made or due him under a plan maintained solely for the purpose of complying with applicable workers' compensation, unemployment compensation, or disability insurance laws.

(2) No more than 501 Hours of Service shall be credited to an Employee under Paragraph (a)(3) of this definition on account of any single continuous period during which no duties are performed by him, except to the extent otherwise provided in the Plan.

(3) No Hours of Service shall be credited to an Employee with respect to payments solely to reimburse for medical or medically related expenses.

(4) No Hours of Service shall be credited twice.

(5) Hours of Service shall be credited at least as liberally as required by the rules set forth in Sections 2530.200b-2(b) and (c) of the Labor regulations.

(6) In the case of an Employee who is such solely by reason of service as a leased employee within the meaning of Section 414(n) or 414(o) of the Code, Hours of Service shall be credited as if such Employee were employed and paid with respect to such service (or with respect to any related absences or entitlements) by the Participating Company or Affiliated Company that is the recipient thereof.

(d) Subject to Part A-7 of Appendix A, an Hour of Service shall include, for any Former PACMA Employee, each hour which would have been credited under (a), (b) and (c) above for service performed with PACMA prior to July 30, 2004.

"Investment Medium" means any fund, contract, obligation, or other mode of investment to which a Participant may direct the investment of the assets of his Account.

"Leased Employee" means any person (other than an employee of a Participating Company or Affiliated Company) who pursuant to an agreement between a Participating Company or Affiliated Company and any other person ("leasing organization") has performed services for a Participating Company or Affiliated Company (or for a Participating Company or Affiliated Company and related persons determined in accordance with Section 414(n)(6) of the Code) on a substantially full-time basis for a period of at least one year, and such services are performed under primary direction or control by a Participating Company or Affiliated Company.

A Leased Employee shall not be considered an Employee of a Participating Company or Affiliated Company if: (a) such individual is covered by a money purchase pension plan maintained by the leasing organization and providing (1) a nonintegrated employer contribution rate of at least 10 percent of compensation, as defined in Section 415 (c)(3) of the Code, but including amounts contributed pursuant to a salary reduction agreement which are excludable from the individual's gross income under Sections 125, 402(e)(3), 402(h)(1)(B), or 403(b) of the Code, (2) immediate participation, and (3) full and immediate vesting; and (b) leased employees do not constitute more than 20 percent of the recipient's non-highly compensated work force.

"Limitation Year" means the Plan Year or such other 12-consecutive-month period as may be designated by the Company.

"Matching Contributions" means the amounts contributed by the Company prior to December 31, 1999, which are credited to Participants' Company Match Accounts.

"Non-Highly Compensated Eligible Employee" means an Eligible Employee who does not meet the definition of a Highly Compensated Eligible Employee.

"Normal Retirement Age" means, for any Participant, the date on which he attains Age 65.

"Normal Retirement Date" means, for any Participant, the first day of the month coincident with or next following his attainment of Normal Retirement Age.

"Old Plan Contributions" means contributions by the Company which had been transferred to the Fund on account of profits prior to April 1, 1970, which are credited to Participants' Old Plan Accounts.

"PACMA" means the Pennsylvania Agricultural Commodities Merchandising Association.

"Participant" means an individual for whom one or more Accounts are maintained under the Plan.

"Participating Company" means the Company and each other organization which is authorized by the Board of Directors to adopt this Plan by action of its board of directors or other governing body.

"Payroll Period" means a weekly, bi-weekly, semi-monthly, or monthly pay period or such other standard pay period of the Participating Company applicable to the class of Employees of which the Eligible Employee is a part.

"Plan" means The Perdue Savings Plan, a profit-sharing plan, as set forth herein.

"Plan Year" means the twelve-month period commencing each January 1 and ending on the next following December 31.

"Prior Matching Contributions" means the amounts contributed by the Company, which matched the Employee Prior Plan Contributions made by a Participant prior to January 1, 1987, and which are credited to such Participant's Company Prior Match Account.

"Qualified Domestic Relations Order" means a domestic relations order (within the meaning of Section 414(p)(1)(B) of the Code) which creates or recognizes the existence of an Alternate Payee's rights to, or assigns to an Alternate Payee the right to receive all or a portion of the benefits payable with respect to a Participant under the Plan, and is determined by the Committee to satisfy the requirements of Section 414(p) of the Code.

"Qualified Military Service" means any service (either voluntary or involuntary) by an individual in the Uniformed Services if such individual is entitled to reemployment rights with a Participating Company with respect to such service.

"Required Beginning Date" means, for any Participant:

(a) if he attains Age 70½ after December 31, 2000 and is not a 5-percent owner (within the meaning of Section 416 of the Code) of a Participating Company at any time during the five-Plan-Year period ending in the calendar year in which he attains Age 70½, or thereafter, April 1 of the calendar year following the later of the calendar year in which he has a Severance from Employment or the calendar year in which he attains Age 70½;

(b) if he attains Age 70½ after December 31, 2000 and is a 5-percent owner (within the meaning of Section 416 of the Code) of a Participating

Company at any time during the five-Plan-Year period ending in the calendar year in which he attains Age 70½, or thereafter, April 1 of the calendar year following the calendar year in which he attains Age 70½;

(c) if he attains Age 70½ on or before December 31, 2000, April 1 of the calendar year following the calendar year in which he attains Age 70½.

"Returning Veteran" means a former Employee who on or after December 12, 1994, returns from Qualified Military Service to employment by a Participating Company within the period of time during which his reemployment rights are protected by law.

"Rollover Contributions" means, for any Participant, his rollover contributions as provided in Section 8.1, whether attributable to amounts previously contributed on a before-tax basis, an after-tax basis, or both.

"Safe Harbor Matching Contributions" means the amounts contributed by the Company pursuant to Section 3.4.

"Salary Reduction Contributions" means Salary Reduction Matched Contributions and Salary Reduction Unmatched Contributions.

"Salary Reduction Matched Contributions" means a Participant's Salary Reduction Contributions as provided in Subsection 3.1(a)(1).

"Salary Reduction Unmatched Contributions" means a Participant's Salary Reduction Contributions as provided in Subsection 3.1(a)(2).

"Severance from Employment" means, for any Employee, his death, retirement, resignation, discharge or any absence that causes him to cease to be an Employee.

"Spouse" means the person to whom a Participant is married on any date of reference. A participant's Spouse shall be determined in accordance with IRS Revenue Ruling 2013-17, Department of Labor Technical Release 2013-04, and any subsequent guidance.

"Total Disability" means, with respect to any Participant, a disability with respect to which he is eligible for and receiving benefits under a long-term disability program sponsored by a Participating Company or an Affiliated Company. If the Participant is not participating in a long-term disability program sponsored by the Company or an Affiliated Company, then "Total Disability" shall mean a physical or mental condition of such severity and probable prolonged duration as to entitle the Participant to disability retirement benefits under the federal Social Security Act.

"Trust Agreement" means any agreement and declaration of trust executed under this Plan.

"Trustee" means the corporate trustee or one or more individuals collectively appointed and acting under the Trust Agreement.

"Uniformed Services" means the Armed Forces, the Army National Guard and Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), the commissioned corps of the Public Health Service,

and any other category of persons designated by the President of the United States in time of war or emergency.

“Valuation Date” means each day on which the New York Stock Exchange is open for business.

“Voluntary Contributions” means Voluntary Matched Contributions and Voluntary Unmatched Contributions.

“Voluntary Matched Contributions” means a Participant’s Voluntary Contributions, contributed on an after-tax basis, that were eligible to be matched by Safe Harbor Matching Contributions or by Matching Contributions prior to January 1, 2010, and which are credited to such Participant’s Voluntary Matched Account.

“Voluntary Unmatched Contributions” means a Participant’s Voluntary Contributions, contributed on an after-tax basis, as provided in Subsection 3.1(a)(2), that are or were ineligible to be matched by Safe Harbor Matching Contributions or by Matching Contributions.

“Written Election” means any election, authorization, or application by a Participant or his beneficiary that is made in writing in a form prescribed by the Committee and furnished to the Committee or its delegate. Notwithstanding the foregoing, except as may be prohibited by ERISA, the Code, or other applicable law, a Written Election shall be deemed to include an election, authorization, or application that is made telephonically, electronically, or by any other means authorized by the Committee, in accordance with procedures established by the Committee.

“Year of Eligibility Service” means, for any Employee, a credit used to determine his eligibility to participate under the Plan, as further described in Section 2.2.

“Year of Service” means, for any Employee, a credit used to determine his vested status under the Plan, as further described in Section 6.2.

ARTICLE II

TRANSITION AND ELIGIBILITY TO PARTICIPATE

2.1 Rights Affected and Preservation of Accrued Benefit. Except as provided to the contrary herein, the provisions of this amended and restated Plan shall apply only to Employees who complete an Hour of Service on or after the Effective Date. The rights of any other individual shall be governed by the Plan as in effect upon his Severance from Employment, except to the extent expressly provided in any amendment adopted subsequently thereto.

2.2 Year of Eligibility Service.

(a) An Employee shall be credited with a Year of Eligibility Service as of the close of the 12-consecutive-month period that begins on his Employment Commencement Date if he is credited with 1,000 or more Hours of Service during such period.

(b) An Employee who is not credited with 1,000 Hours of Service during such period shall be credited with a Year of Eligibility Service as of the close of the first Plan Year in which he is credited with 1,000 or more Hours of Service.

2.3 Eligibility to Participate - Salary Reduction Contributions and Voluntary Contributions.

(a) Each Covered Employee as of January 1, 2014 who was eligible to make Salary Reduction and Voluntary Contributions immediately prior to January 1, 2014 shall continue to be an Eligible Employee as of January 1, 2014.

(b) Each Covered Employee who was not eligible to make Salary Reduction and Voluntary Contributions immediately prior to January 1, 2014, and who has attained Age 21, shall become an Eligible Employee upon the later of:

(1) the first Payroll Period beginning after January 1, 2014; or

(2) the first Payroll Period beginning after the Covered Employee has completed 30 days of employment with the Company or an Affiliated Company, if he is then a Covered Employee.

(c) If an individual is not a Covered Employee on the date he would otherwise become an Eligible Employee pursuant to Subsection (b) of this Section, he shall become an Eligible Employee as of the first date thereafter on which he is a Covered Employee.

(d) An Eligible Employee who ceases to be a Covered Employee, by Severance from Employment or otherwise, and who later becomes a Covered Employee, shall become an Eligible Employee as of the date on which he first again completes an Hour of Service as a Covered Employee.

2.4 Eligibility to Participate - Safe Harbor Matching and Discretionary Contributions.

(a) Each Covered Employee who, immediately prior to January 1, 2014, would have been eligible to share in Safe Harbor Matching Contributions (assuming he was making Salary Reduction and/or Voluntary Contributions at the time) shall be a Full Participant as of January 1, 2014.

(b) Each Covered Employee who, immediately prior to January 1, 2014, would not have been eligible to share in Safe Harbor Matching Contributions (assuming he was making Salary Reduction and/or Voluntary Contributions at the time) shall become a Full Participant upon the January 1st, April 1st, July 1st or October 1st coincident with or next following the date he meets the following requirements:

(1) he has attained Age 21; and

(2) he has completed one Year of Eligibility Service, if he is then a Covered Employee.

(c) If an individual is not a Covered Employee on the date he would otherwise become a Full Participant pursuant to Subsection (b) of this Section, he shall become a Full Participant as of the first date thereafter on which he is a Covered Employee.

(d) A Full Participant who ceases to be a Covered Employee, by Severance from Employment or otherwise, and who later becomes a Covered Employee, shall become a Full Participant as of the date on which he first again completes an Hour of Service as a Covered Employee.

2.5 Election to Make Salary Reduction Contributions and/or Voluntary Contributions. Except as provided in Appendix B, each Eligible Employee may elect to make Salary Reduction Contributions and/or Voluntary Contributions and become an active Participant by Written Election. Such Written Election shall authorize the Participating Company to reduce such Eligible Employee's Compensation by an amount determined in accordance with Section 3.1 and to make Salary Reduction Contributions and/or Voluntary Contributions on such Eligible Employee's behalf in the amount of such reduction. Such election shall be effective the earliest date that is administratively practicable, but in no event prior to the first day of the Payroll Period during which such Written Election is received by the Committee.

2.6 Participation in Safe Harbor Matching Contributions. Except as provided in Appendix B, a Full Participant shall share in Safe Harbor Matching Contributions under Section 3.4 for any Payroll Period if Salary Reduction Matched Contributions are made on his behalf in such Payroll Period.

2.7 Participation in Discretionary Contributions. Except as provided in Appendix B, a Full Participant shall share in any Discretionary Contributions under Section 3.5 for any Plan Year in which he both receives Compensation and is a Full Participant, provided that either (a) he remains an Employee as of December 31 of such Plan Year, or (b) he has ceased to be an Employee during, but prior to December 31 of such Plan Year, by reason of his (1) death, (2) Total Disability, or (3) retirement from the

Company after his 65th birthday, or after his 55th birthday and completion of at least 10 Years of Service.

2.8 Data. Each Employee shall furnish to the Committee such data as the Committee may consider necessary for the determination of the Employee's rights and benefits under the Plan and shall otherwise cooperate fully with the Committee in the administration of the Plan.

ARTICLE III

CONTRIBUTIONS TO THE PLAN

3.1 Salary Reduction and/or Voluntary Contributions.

(a) When an Eligible Employee makes a Written Election under Section 2.5 to make Salary Reduction Contributions and/or Voluntary Contributions, he shall elect (1) the percentage by which his Compensation shall be reduced on account of such Salary Reduction Contributions and/or Voluntary Contributions, and (2) how such percentage is to be allocated between Salary Reduction Contributions and Voluntary Contributions; provided, that effective October 1, 2008, such percentage elections shall be rounded to the nearest whole percent. Such Salary Reduction Contributions and Voluntary Contributions shall be subject to the following limitations:

(1) The total amount of an Eligible Employee's Salary Reduction Contributions and Voluntary Contributions shall be between one percent (1%) and seventy-five percent (75%) of the Eligible Employee's Compensation.

(2) An Eligible Employee's Salary Reduction Contributions may consist of (i) Salary Reduction Matched Contributions, which shall be between one percent (1%) and five percent (5%) of the Eligible Employee's Compensation, as well as (ii) Salary Reduction Unmatched Contributions. Effective July 1, 2010, all Catch-Up Contributions shall be Salary Reduction Unmatched Contribution.

(3) Effective January 1, 2010, Eligible Employee's shall not be permitted to make Voluntary Matched Contributions.

(4) The Participating Company shall contribute an amount equal to such percentages of the Eligible Employee's Compensation to the Fund for credit to the Eligible Employee's 401(k) Account, and/or Voluntary Unmatched Account.

(b) Salary Reduction Contributions made on behalf of an Eligible Employee under this Plan (other than those permitted under Subsection (c) of this Section), together with elective deferrals under any other plan or arrangement maintained by any Participating Company or Affiliated Company (other than those permitted under Section 414(v) of the Code), shall not exceed the dollar limit set forth in Section 402(g) of the Code (as adjusted in accordance therewith) for any calendar year. To the extent necessary to satisfy this limitation for any year:

(1) elections under Subsection (a) of this Section shall be prospectively restricted; and,

(2) after application of Subparagraph (1), the excess Salary Reduction Contributions and excess elective deferrals under any other plan or arrangement maintained by any Participating Company or Affiliated Company (including any earnings attributable thereto through the end of the calendar year in which such contributions were made) shall be paid to the Participant on or before the April 15 first following the calendar year in which such contributions were made. If the Salary Reduction Contributions plus elective deferrals described above do not exceed such

limitation, but Salary Reduction Contributions, plus the elective deferrals, as defined in Section 402(g)(3) of the Code, under any other plan for any Participant, exceed such limitation for any calendar year, upon the written request of the Participant made on or before the March 1 first following such calendar year, the excess, including any earnings attributable thereto through the end of such calendar year, designated by the Participant to be distributed from the Plan shall be paid to the Participant on or before the April 15 first following such calendar year. In addition, in the event that any Safe Harbor Matching Contributions would otherwise be allocable with respect to such excess deferrals distributed pursuant to this Subsection (b)(2), such Safe Harbor Matching Contributions, as adjusted for earnings through the end of the calendar year in which such contributions were made, shall be forfeited under Subsection 6.5(a) and shall be available to be treated as an Applied Forfeiture under the terms of the Plan.

(c) All Eligible Employees who are eligible to make Salary Reduction Contributions under the Plan and who have attained Age 50 before the close of the tax year shall be eligible to make Catch-Up Contributions in accordance with, and subject to the limitations of, Section 414(v) of the Code. Any election to make a Catch-Up Contribution shall be a flat dollar amount. Such Catch-Up Contributions shall not be taken into account for purposes of the provisions of the Plan implementing the required limitations of Sections 402(g) and 415 of the Code, nor in applying the maximum percentage limitation under Subsection 3.1(a)(1) of the Plan. The Plan shall not be treated as failing to satisfy the provisions of the Plan implementing the requirements of Section 401(k)(3), 401(k)(11), 401(k)(12), 410(b), or 416 of the Code, as applicable, by reason of the making of such Catch-Up Contributions. Effective July 1, 2010, all Catch-Up Contributions shall be considered Salary Unmatched Contributions for all purposes of the Plan.

3.2 Change of Deferral Rate. A Participant may without penalty change the percentage of Compensation (or flat dollar amount in the case of Catch-Up Contributions) designated by him as his contribution rate under Section 3.1, to any percentage (or flat dollar amount in the case of Catch-Up Contributions) permitted by such Section, and such percentage shall remain in effect until so changed. Any such change shall become effective as of the earliest date that is administratively practicable, but in no event prior to the first day of the Payroll Period during which a Written Election for such change is received by the Committee.

3.3 Discontinuance of Salary Reduction, Voluntary and/or Catch-Up Contributions. A Participant may discontinue his Salary Reduction Contributions, Voluntary Contributions and/or Catch-Up Contributions at any time. Such discontinuance shall become effective as of the earliest date that is administratively practicable, but in no event prior to the first day of the Payroll Period during which a Written Election for such discontinuance is received by the Committee.

3.4 Safe Harbor Matching Contributions. Subject to Section 3.8, and except as otherwise provided in Appendix B, a Participating Company shall contribute to the Fund for each Payroll Period an amount equal to one hundred percent (100%) of all Eligible Employees' Salary Reduction Matched Contributions (including Catch-Up Contributions, if any, made prior to June 30, 2010 that also qualified as Salary Reduction Matched Contributions), offset by the amount, if any, of any Applied Forfeitures during

such Payroll Period; provided, that the contributions under this Section for any Plan Year shall not cause the total contributions by the Participating Company to exceed the maximum allowable current deduction under the applicable provisions of the Code. For purposes of satisfying the requirements of Section 401(m)(11) of the Code, Safe Harbor Matching Contributions shall be taken into account for a Plan Year in accordance with the allocation and timing rules of Section 1.401(m)-1(b)(4)(ii)(A) of the Treasury Regulations.

3.5 Discretionary Contributions. Subject to Section 3.8, and except as otherwise provided in Appendix B, each Participating Company shall contribute to the Fund for each Plan Year such amount as shall be determined by the Board of Directors, in its sole discretion, as of the close of the Plan Year, offset by the amount, if any, of any Applied Forfeitures during such Plan Year; provided, that the contributions under this Section for any Plan Year shall not cause the total contributions by the Participating Company to exceed the maximum allowable current deduction under the applicable provisions of the Code. Such contributions shall be allocated to the Discretionary Contribution Accounts of those Full Participants eligible to share in Discretionary Contributions in accordance with Section 2.7 as follows:

(a) the Discretionary Contribution Account of each Full Participant who was a Full Participant for a full 12 months of the Plan Year shall receive an allocation of a uniform, fixed dollar amount; and

(b) the Discretionary Contribution Account of each Full Participant who was a Full Participant for less than 12 full months of the Plan Year (whether by reason of his death, Total Disability, retirement, or transfer to or from a union-represented position during the Plan Year, or his satisfaction of the requirements to become a Full Participant after January 1 of the Plan Year) shall receive a prorated share of the allocation described in Subsection (a). Such prorated share shall equal the product of (1) the fixed dollar amount determined under Subsection (a), and (2) a fraction, the numerator of which is the number of full calendar months during the Plan Year in which the individual was a Full Participant, and the denominator of which is 12.

3.6 Timing and Deductibility of Contributions. Safe Harbor Matching Contributions and Discretionary Contributions under this Article for any Plan Year shall be made no later than the last date on which amounts so paid may be deducted for Federal income tax purposes for the taxable year of the employer in which the Plan Year ends. All Participating Company contributions are expressly conditioned upon their deductibility for Federal income tax purposes. Amounts contributed as Salary Reduction Contributions, Rollover Contributions, or Voluntary Contributions will be remitted to the Trustee as soon as practicable, but no later than the fifteenth (15th) business day of the month following the month in which such contributions were received or withheld from the Participant's Compensation.

3.7 Fund. The contributions deposited by the Participating Company in the Fund in accordance with this Article shall constitute a fund held for the benefit of Participants and their eligible beneficiaries under and in accordance with this Plan. No part of the principal or income of the Fund shall be used for, or diverted to, purposes other than for the exclusive benefit of such Participants and their eligible beneficiaries

(including necessary administrative costs); provided, that in the case of a contribution made by the Participating Company as a mistake of fact, or for which a tax deduction is disallowed, in whole or in part, by the Internal Revenue Service, the Participating Company shall be entitled to a refund of said contributions, which must be made within one year after payment of a contribution made as a mistake of fact, or within one year after disallowance of the tax deduction, to the extent of such disallowance.

3.8 Limitation on Annual Additions.

(a) Notwithstanding anything in this Plan to the contrary, except to the extent permitted under Subsection 3.1(c) of the Plan and Section 414(v) of the Code, the total Annual Additions credited to a Participant's Account under the Plan (and under all other defined contribution plans, defined benefit plans, and welfare benefit fund to which a Participating Company or an Affiliated Company contributes) shall not exceed the lesser of (1) 100% of the Participant's Compensation for such Limitation Year, or (2) the dollar limit set forth in Section 415(c)(1)(A) of the Code (as indexed for inflation in accordance therewith). Notwithstanding the foregoing, the 100% of Compensation limitation described in the immediately preceding sentence shall not apply to (1) any contribution for medical benefits (within the meaning of Section 419A(f)(2) of the Code) after a Participant's Severance from Employment, which contribution is otherwise treated as an Annual Addition, or (2) any amount otherwise treated as an Annual Addition under Section 415(l)(1) of the Code.

(b) If the amounts otherwise allocable to a Participant's Account under the Plan would exceed the limitations set forth in Subsection 3.8(a) above as a result of the reallocation of forfeitures, a reasonable error in estimating the Participant's Compensation, a reasonable error in determining the amount of Salary Reduction Contributions that may be made with respect to the Participant under the limits of this Section, or such other circumstances as permitted by law, the Committee shall determine which portion, if any, of such excess amount is attributable to the Participant's Salary Reduction Contributions, Voluntary Contributions, Safe Harbor Matching, and/or Discretionary Contributions, until such amount has been exhausted and shall take the following steps to correct such violation:

(1) Excess Voluntary Contributions and earnings thereon shall be paid to the Participant as soon as is administratively feasible.

(2) Excess Salary Reduction Contributions and earnings thereon shall be paid to the Participant as soon as is administratively feasible.

(3) (A) While the Participant remains a Covered Employee, his excess Safe Harbor Matching and Discretionary Contributions (whichever may be applicable) shall be held in a suspense account (which shall not share in investment gains and losses of the Fund) by the Trustee until the following Limitation Year (or any succeeding Plan Years), at which time such amounts shall be allocated to the Participant's Account before any Safe Harbor Matching and Discretionary Contributions (whichever may be applicable) are made on his behalf for such Plan Year; and

(B) When the Participant ceases to be a Covered Employee, his excess Safe Harbor Matching and Discretionary Contributions (whichever may be applicable), along with earnings thereon, held in the suspense account shall be allocated in the following Plan Year (or any succeeding Plan Year) to the Accounts of other Participants in the Plan.

(4) In the event the Plan is terminated, any amounts credited to the limitations accounts described in Subsection 3.8(b)(3) above, which have not been reallocated as set forth herein shall, upon the Participating Company's request, be returned to the Participating Company by the Trustee.

(5) Notwithstanding the foregoing, any excess Annual Additions shall be corrected in the manner set forth in Revenue Procedure 2013-12, as the same may be amended or superseded from time to time.

(c) In the event (1) any member of the Controlled Group (as such term may be modified by Section 415(h) of the Code) other than a Participating Company maintains a retirement plan subject to Section 415 of the Code, and (2) an individual participates in both a Participating Company's plan and a plan of such other member of the Controlled Group during any Limitation Year, the Annual Additions credited to any Participant's Accounts in any such Limitation Year shall be further limited by reason of the existence of all other such retirement plans maintained by such other members of the Controlled Group, to the extent such reduction is required by Section 415 of the Code. If any such reduction in the Annual Additions to a Participant's Accounts is required for this reason, the same provisions as stated in Subsection 3.8(b) above shall apply.

(d) To the extent a Participant's benefit is subject to provisions of Section 415 of the Code which have not been set forth in the Plan, such provisions are hereby incorporated into the Plan by reference and for all purposes shall be deemed part of the Plan.

3.9 Erroneous Allocations. No Participant shall be entitled to any allocations to his Account or earnings thereon made or allocated to his Account in excess of those permitted under any provision of the Plan or the Code. If it is determined at any time that an error was made in accepting and allocating contributions to any Participant's Account for any Plan Year or in excluding or including any person as a Participant, then the Committee, in its discretion, shall determine the manner in which such error shall be corrected. The Accounts of all Participants may be revised, if necessary, in order to correct such error.

3.10 Limitation on Voluntary Contributions.

(a) For any Plan Year, the Average Contribution Percentage for the Highly Compensated Eligible Employees shall not exceed the greater of:

(1) one hundred twenty-five percent (125%) of the Average Contribution Percentage for all Non-Highly Compensated Eligible Employees; or

(2) the lesser of:

(A) two hundred percent (200%) of the Average Contribution Percentage for all Non-Highly Compensated Eligible Employees; or

(B) two percent (2%) plus the Average Contribution Percentage for all Non-Highly Compensated Eligible Employees.

(b) For purposes of Subsection (a):

(1) The Average Contribution Percentage for all Eligible Employees shall be based on:

(A) Contribution Percentages for the Testing Plan Year, i.e., using contributions and Compensation for the Testing Plan Year; and

(B) the Eligible Employee's status as a Highly Compensated Eligible Employee or Non-Highly Compensated Eligible Employee for the Testing Plan Year, i.e., based on his Compensation for the Preceding Plan Year and his status as an Eligible Employee for the Testing Plan Year.

(2) For purposes of Paragraph (1) of this Subsection, the term "Testing Plan Year" shall mean the Plan Year for which the test in Subsection (a) of this Section is being performed, and the term "Preceding Plan Year" shall mean the Plan Year immediately preceding the Testing Plan Year.

(c) If the Plan and any other plan(s) maintained by a Participating Company or Affiliated Company are treated as a single plan for purposes of Section 401(a)(4) or Section 410(b) of the Code, the limitations in Subsection (a) of this Section shall be applied by treating the Plan and such other plan(s) as a single plan.

(d) In addition to the testing method described in Subsections 3.10(a) and (b), the Committee may, at its discretion, use any other testing method permitted under Section 401(m) of the Code and the regulations promulgated thereunder or as permitted by law.

(e) This Section 3.10 shall not apply to Bargaining Unit Members.

3.11 Prevention of Violation of Limitation on Voluntary Contributions.

(a) The Committee shall monitor the level of Participants' Voluntary Contributions and elective deferrals, employee contributions, and employer matching contributions under any other qualified retirement plan maintained by a Participating Company or Affiliated Company to insure against exceeding the limits of Section 3.10.

(b) If the Committee determines that the limits of Section 3.10 have been exceeded, then the Voluntary Contributions for Highly Compensated Eligible Employees shall be reduced as follows:

(1) The aggregate amount of Voluntary Contributions that must be distributed to Highly Compensated Eligible Employees shall be determined as follows:

(A) The Committee shall calculate the amount by which the Voluntary Contributions for each Highly Compensated Eligible Employee would have to be reduced in order to obtain the highest Average Contribution Percentage that would permit one of the tests in Subsection 3.10(a) to be satisfied.

(B) The amount described in Clause (A) above shall be determined in order of Actual Contribution Percentages, beginning with the Highly Compensated Eligible Employee whose Actual Contribution Percentage is the highest.

(2) The aggregate amount determined under Subparagraph (1) of this Subsection shall be allocated among the Highly Compensated Eligible Employees as follows: the Voluntary Contributions for the Highly Compensated Eligible Employee(s) with the highest dollar amount of Voluntary Contributions shall be reduced until either (A) the total reduction(s) equal the required aggregate reduction determined under Subparagraph (1) of this Subsection, or (B) the reduced amount of Voluntary Contributions for the affected Highly Compensated Eligible Employee(s) equals those of the Highly Compensated Eligible Employee(s) with the next highest dollar amount of Voluntary Contributions. If necessary, this process shall be repeated until the aggregate dollar amount of reductions equals the required aggregate reduction determined under Subparagraph (1) of this Subsection. Any Safe-Harbor Matching Contributions that were made with respect to Voluntary Contributions refunded pursuant to this Subsection (b)(2), as adjusted for earnings, shall be forfeited under Subsection 6.5(a) and shall be available to be treated as an Applied Forfeiture under the terms of the Plan.

(3) Not later than the end of the Plan Year following the close of the Plan Year for which such contributions were made, the amount of the required reduction to any Highly Compensated Eligible Employee's Voluntary Contributions, with earnings attributable thereto (as determined in accordance with applicable Treasury regulations), at the Committee's direction, shall be paid to the Highly Compensated Eligible Employees; provided, however, that, for any Participant who is also a participant in any other qualified retirement plan maintained by a Participating Company or Affiliated Company under which the Participant makes employee contributions or is credited with employer matching contributions for the year, the Committee shall coordinate corrective actions under this Plan and such other plan for the year. If the Plan and any other plan maintained by a Participating Company or Affiliated Company are treated as a single plan pursuant to Subsection 3.10(c), the Committee shall coordinate corrective actions under the Plan and such other plan for the year.

(4) In addition to the correction method described in Subsections 3.11(b)(2) and (3), the Committee may, in its discretion, use any other correction method permitted under Section 401(m) of the Code and the regulations promulgated thereunder or as otherwise permitted by law. To the extent required to be included in the Plan document for any reason, Section 401(m) of the Code and such regulations, as the same may be amended from time to time, are hereby incorporated by reference.

3.12 Additional Limitation on Salary Reduction Contributions. For any Plan Year, this Section 3.12 shall apply to those Participants who are eligible to make Salary Reduction Contributions, but are not eligible to receive Safe Harbor Matching Contributions.

(a) For any Plan Year, the Average Deferral Percentage for the Highly Compensated Eligible Employees shall not exceed the greater of:

(1) one hundred twenty-five percent (125%) of the Average Deferral Percentage for all Non-Highly Compensated Eligible Employees; or

(2) the lesser of:

(C) two hundred percent (200%) of the Average Deferral Percentage for all Non-Highly Compensated Eligible Employees; or

(D) two percent (2%) plus the Average Deferral Percentage for all Non-Highly Compensated Eligible Employees.

(b) For purposes of Subsection (a):

(1) The Average Deferral Percentage for all Eligible Employees shall be based on:

(C) Deferral Percentages for the Testing Plan Year, i.e., using contributions and Compensation for the Testing Plan Year; and

(D) the Eligible Employee's status as a Highly Compensated Eligible Employee or Non-Highly Compensated Eligible Employee for the Testing Plan Year, i.e., based on his Compensation for the Preceding Plan Year and his status as an Eligible Employee for the Testing Plan Year.

(2) For purposes of Paragraph (1) of this Subsection, the term "Testing Plan Year" shall mean the Plan Year for which the test in Subsection (a) of this Section is being performed, and the term "Preceding Plan Year" shall mean the Plan Year immediately preceding the Testing Plan Year.

(c) If the Plan and any other plan(s) maintained by a Participating Company or Affiliated Company are treated as a single plan for purposes of Section 401(a)(4) or Section 410(b) of the Code, the limitations in Subsection (a) of this Section shall be applied by treating the Plan and such other plan(s) as a single plan.

(d) In addition to the testing method described in Subsections 3.12(a) and (b), the Committee may, at its discretion, use any other testing method permitted under Section 401(k) of the Code and the regulations promulgated thereunder or as permitted by law.

3.13 Prevention of Violation of Limitation on Salary Reduction Contributions.

(a) The Committee shall monitor the level of Participants' Voluntary Contributions and elective deferrals, employee contributions, and employer matching contributions under any other qualified retirement plan maintained by a

Participating Company or Affiliated Company to insure against exceeding the limits of Section 3.12.

(b) If the Committee determines that the limits of Section 3.12 have been exceeded, then the Salary Reduction Contributions for Highly Compensated Eligible Employees shall be reduced as follows:

(1) The aggregate amount of Salary Reduction Contributions that must be distributed to Highly Compensated Eligible Employees shall be determined as follows:

(A) The Committee shall calculate the amount by which the Salary Reduction Contributions for each Highly Compensated Eligible Employee would have to be reduced in order to obtain the highest Average Deferral Percentage that would permit one of the tests in Subsection 3.12(a) to be satisfied.

(B) The amount described in Clause (A) above shall be determined in order of Actual Deferral Percentages, beginning with the Highly Compensated Eligible Employee whose Actual Deferral Percentage is the highest.

(2) The aggregate amount determined under Subparagraph (1) of this Subsection shall be allocated among the Highly Compensated Eligible Employees as follows: the Salary Reduction Contributions for the Highly Compensated Eligible Employee(s) with the highest dollar amount of Salary Reduction Contributions shall be reduced until either (A) the total reduction(s) equal the required aggregate reduction determined under Subparagraph (1) of this Subsection, or (B) the reduced amount of Salary Reduction Contributions for the affected Highly Compensated Eligible Employee(s) equals those of the Highly Compensated Eligible Employee(s) with the next highest dollar amount of Voluntary Contributions. If necessary, this process shall be repeated until the aggregate dollar amount of reductions equals the required aggregate reduction determined under Subparagraph (1) of this Subsection. Any non-Safe Harbor Matching Contributions that were made with respect to Salary Reduction Contributions refunded pursuant to this Subsection (b)(2), as adjusted for earnings, shall be forfeited under Subsection 6.5(a) and shall be available to be treated as an Applied Forfeiture under the terms of the Plan.

(3) Not later than the end of the Plan Year following the close of the Plan Year for which such contributions were made, the amount of the required reduction to any Highly Compensated Eligible Employee's Salary Reduction Contributions, with earnings attributable thereto (as determined in accordance with applicable Treasury regulations), at the Committee's direction, shall be paid to the Highly Compensated Eligible Employees; provided, however, that, for any Participant who is also a participant in any other qualified retirement plan maintained by a Participating Company or Affiliated Company under which the Participant makes Salary Reduction for the year, the Committee shall coordinate corrective actions under this Plan and such other plan for the year. If the Plan and any other plan maintained by a Participating Company or Affiliated Company are treated as a single plan pursuant to Subsection 3.10(c), the Committee shall coordinate corrective actions under the Plan and such other plan for the year.

(4) In addition to the correction method described in Subsections 3.13(b)(2) and (3), the Committee may, in its discretion, use any other correction method permitted under Section 401(k) of the Code and the regulations promulgated thereunder or as otherwise permitted by law. To the extent required to be included in the Plan document for any reason, Section 401(k) of the Code and such regulations, as the same may be amended from time to time, are hereby incorporated by reference.

ARTICLE IV

PARTICIPANTS' ACCOUNTS

4.1 Accounts. All contributions and earnings thereon may be invested in one commingled Fund for the benefit of all Participants. However, in order that the interest of each Participant may be accurately determined and computed, separate Accounts shall be maintained for each Participant, and each Participant's Accounts shall be made up of subaccounts reflecting his investment elections pursuant to Section 15.5. These Accounts shall represent the Participant's individual interest in the Fund. All contributions shall be credited to Participants' Accounts as set forth in Article III.

4.2 Valuation. The value of each Investment Medium in the Fund shall be computed by the Trustee as of the close of business on each Valuation Date on the basis of the fair market value of the assets of the Fund.

4.3 Apportionment of Gain or Loss. The value of each Investment Medium in the Fund, as computed pursuant to Section 4.2, shall be compared with the value of such Investment Medium in the Fund as of the preceding Valuation Date. Any difference in the value, not including contributions or distributions made since the preceding Valuation Date, shall be the net increase or decrease of such Investment Medium in the Fund, and such amount shall be ratably apportioned by the Trustee on its books, among the Participants' Accounts which are invested in such Investment Medium at the current Valuation Date.

4.4 Accounting for Allocations. The Committee shall establish or provide for the establishment of accounting procedures for the purpose of making the allocations, valuations and adjustments to Participants' Accounts provided for in this Article. From time to time such procedures may be modified for the purpose of achieving equitable and non-discriminatory allocations among the Accounts of Participants in accordance with the general concepts of the Plan and the provisions of this Article.

ARTICLE V
DISTRIBUTION

5.1 General. The interest of each Participant in the Fund shall be distributed in the manner, in the amount, and at the time provided in this Article, except as provided in Article IX and except in the event of the termination of the Plan. Anything to the contrary notwithstanding, any amount payable as an annuity hereunder shall be provided through the purchase of an annuity contract from an insurance company, which shall be purchased using the nonforfeitable portion of the Participant's Account that is to be payable in the form of an annuity. The provisions of this Article shall be construed in accordance with Section 401(a)(9) of the Code and regulations thereunder, including the incidental death benefit requirements of Section 401(a)(9)(G) of the Code.

5.2 Severance from Employment. A Participant who has a Severance from Employment for reasons other than death or Total Disability shall have his nonforfeitable interest in his Account paid to him or applied for his benefit in accordance with the provisions of this Article.

5.3 Total Disability.

(a) If a Participant who is an Employee suffers a Total Disability and has a Severance from Employment due to his Total Disability, his Account shall be paid to him or applied for his benefit in accordance with the provisions of this Article following the determination of his Total Disability and his Severance from Employment.

(b) Total Disability shall be determined by the Committee, which may consult with a medical examiner selected by it. The medical examiner shall have the right to make such physical examinations and other investigations as may be reasonably required to determine Total Disability.

5.4 Mode of Distribution of Retirement or Disability Benefits.

(a) Except as provided in Subsection (b) of this Section, a Participant shall have his Account paid to him in a single-sum payment.

(b) In the case of a Participant with a nonforfeitable interest in a Former MPP Account, subject to the right to elect an optional form of benefit pursuant to Paragraph (3) of this Subsection, the requirements of Paragraphs (1) and (2) of this Subsection shall apply to any distribution of a Participant's interest and will take precedence over any inconsistent provisions of this Plan.

(1) With respect to the Former MPP Account only, the normal form of benefit for each married Participant shall be a joint and survivor annuity payable in monthly installments to the Participant for his lifetime and with one hundred percent (100%) of the amount of such monthly installment payable after the death of the Participant to the surviving Spouse of such Participant, if then living, for the life of such surviving Spouse. Notwithstanding the foregoing, the Participant may, however, elect (without the necessity of obtaining spousal consent) to receive a larger annuity benefit during his lifetime with fifty percent (50%) of the amount of such monthly installment

payable after the death of the Participant to the surviving Spouse of such Participant, if then living, for the life of such surviving Spouse.

(2) With respect to the Former MPP Account only, the normal form of benefit for each unmarried Participant shall be a single life annuity with equal monthly installments payable to the retired Participant for his lifetime.

(3) With respect to the Former MPP Account only, in the case of retirement where the Participant has no Spouse at the time that his benefit is to commence or where, if married, the Participant has obtained spousal consent in accordance with the provisions of Subsection 5.5(b), a Participant may elect in writing to have his nonforfeitable interest in his Former MPP Account paid to him or applied for his benefit in accordance with either of the following modes of payment in lieu of the normal mode of distribution as determined under Paragraphs (1) or (2), above:

(A) a single-sum payment equal to the vested balance of his Former MPP Account; or

(B) a single life annuity with monthly installments payable for the life of the Participant.

(4) Notwithstanding any other provision in this Article to the contrary, if the vested portion of the Participant's total Account (excluding the value of his Rollover Account, if any) as of his Severance from Employment or death, whichever applies, does not exceed \$5,000, his total vested Account (including his Former MPP Account and his Rollover Account, if any) shall be paid to the Participant (subject to Section 5.8(a)(2)) or his beneficiary, if applicable, in a single sum without obtaining the consent of the Participant or the Participant's Spouse (if any).

5.5 Rules for Election of Optional Mode of Retirement or Disability Benefits. A Participant described in Subsection 5.4(b) may elect an optional mode of payment under that Subsection for his Former MPP Account by filing a written notice with the Committee in the form and manner prescribed by the Committee. The following rules shall be applied in a uniform and non-discriminatory manner with respect to the election of optional modes of payments.

(a) A Participant may elect an optional mode of payment at any time not earlier than 180 days prior to his Benefit Commencement Date.

(b) A Participant who does not establish to the satisfaction of the Committee that he has no Spouse on his Benefit Commencement Date may elect to receive an optional mode of payment only if:

(1) (A) his Spouse (or the Spouse's legal guardian if the Spouse is legally incompetent) executes a written instrument whereby such Spouse:

(i) consents not to receive the joint and survivor annuity described in Paragraph 5.4(b)(1);

(ii) consents to the specific optional mode elected by the Participant or to the Participant's right to choose any optional mode without any further consent by the Spouse; and

(B) such instrument acknowledges the effect of the election to which the Spouse's consent is being given and is witnessed by a Plan representative or a notary public; or

(2) the Participant:

(A) establishes to the satisfaction of the Committee that his Spouse cannot be located; or

(B) furnishes a court order to the Committee establishing that the Participant is legally separated or has been abandoned (within the meaning of local law), unless a Qualified Domestic Relations Order pertaining to such Participant provides that the Spouse's consent must be obtained; or

(3) the Spouse has previously given consent in accordance with this Subsection and consented to the Participant's right to choose any optional mode without further consent by the Spouse.

The consent of a Spouse in accordance with this Subsection (b) shall not be effective with respect to other Spouses of the Participant prior to the Participant's Benefit Commencement Date, and an election to which Paragraph (2) of this Subsection (b) applies shall become void if the circumstances causing the consent of the Spouse not to be required no longer exist prior to the Participant's Benefit Commencement Date.

(c) A Participant may revoke an election under Subsection (b) of this Section. Such revocation may be made at any time before the first distribution to the Participant is actually made. Such revocation shall not void any prospectively effective consent given by his Spouse in connection with the revoked election.

(d) If a Participant's Spouse dies before the Participant's Benefit Commencement Date, but after an election of a joint and survivor annuity has been made hereunder, the election shall be automatically revoked.

(e) In the event of the divorce of a Participant prior to his Benefit Commencement Date, but following the Participant's election of a form of benefit, the election shall remain in effect unless the election is revoked by the Participant, the Participant remarries, or a Qualified Domestic Relations Order provides otherwise.

5.6 Explanations to Participants.

(a) The Committee shall provide to each Participant who has a Former MPP Account and whose nonforfeitable interest in his total Account exceeds \$5,000, a written explanation of:

(1) the terms and conditions of each optional mode of payment, including information explaining the relative values of each mode of benefit;

(2) the Participant's right to elect an optional mode of payment and the effect of such an election;

(3) the rights of the Participant's Spouse with respect to the Participant's election of certain optional modes of payment; and

(4) the Participant's right to revoke an election to receive an optional mode of payment and the effect of such revocation.

(b) Except as provided in Subsection (c) hereof, the explanation described in Subsection (a) hereof shall be provided:

(1) no more than 180 days before the Participant's Benefit Commencement Date; and

(2) no less than 30 days before the first distribution to the Participant is actually made.

(c) Notwithstanding Subsection (b) hereof, such explanation may be provided less than 30 days before the first distribution is actually made, provided that:

(1) the Participant elects to waive the requirement that the explanation be furnished at least 30 days before a distribution of benefits begins;

(2) the Participant's Spouse has consented to the chosen mode of payment, if required under Subsection 5.5(b); and

(3) the distribution commences more than seven days after the explanation is provided.

(d) With respect to the Spouse's annuity described in Paragraph 5.9(b)(1), the Committee shall provide to each Participant a written explanation of:

(1) the terms and conditions of such Spouse's annuity;

(2) the Participant's and the Spouse's rights to waive such annuity and the effect of such waiver; and

(3) the rights of the Participant's Spouse with respect to the Participant's waiver of such annuity; and

(4) the Participant's right to revoke a waiver of such annuity and the effect of such revocation.

5.7 Valuation for Distribution. For the purposes of paying the amounts to be distributed to a Participant or his beneficiaries under the provisions of this Article, the value of the Fund and the amount of the Participant's nonforfeitable interest shall be determined in accordance with the provisions of Article IV as of the Valuation Date coincident with or immediately preceding the date of any payment (Such amount shall be adjusted to take into account additional contributions, if any, which have been or are to be allocated to the Participant's Account since that Valuation Date, and any distributions or withdrawals made since that date. Notwithstanding the foregoing, the Participant's Account shall be reduced by the amount necessary to repay any outstanding loan from the Plan and interest thereon to the date the Committee declares such loan satisfied, unless such loan is repaid as provided in Subsection 10.4(d).

5.8 Timing of Distribution. Any Participant who has a Severance from Employment for any reason other than death shall be entitled to receive his nonforfeitable interest in his Account, pursuant to the following rules:

(a) (1) If the Participant's nonforfeitable interest in his Account is \$5,000 or less (excluding the value of his Rollover Account, if any), or if the Participant has attained Normal Retirement Age, the Participant's Benefit Commencement Date shall be the earliest practicable date following his Severance from Employment.

(2) In the event of a mandatory distribution greater than \$1,000 (determined after including the value of the Participant's Rollover Account, if any) in accordance with the provisions of Subsection 5.8(a)(1), if the Participant does not elect to have such distribution paid directly to an eligible retirement plan specified by the Participant in a direct rollover in accordance with Section 5.11 or to receive the distribution directly, then the Committee will pay the distribution in a direct rollover to an individual retirement account designated by the Committee.

(b) (1) If the Participant has not attained Normal Retirement Age and his nonforfeitable interest exceeds \$5,000, his Benefit Commencement Date shall be the earliest practicable date following his Severance from Employment, except that, if the Participant does not consent to such distribution, distribution of his benefits shall commence on any later date elected by the Participant that is not later than his Normal Retirement Date, at which time his nonforfeitable interest shall be automatically paid to him. A Participant's election to receive payment prior to his Normal Retirement Date may be made no earlier than 180 days prior to the Benefit Commencement Date elected by the Participant.

(2) The Committee shall inform each Participant who is subject to this Subsection (b) of his right to defer distribution. Such notice shall be furnished not less than 30 days nor more than 180 days prior to the date of any distribution that occurs prior to his Normal Retirement Date, except that such notice may be furnished less than 30 days prior to the date of distribution if (A) the Committee informs the Participant that the Participant has the right to a period of at least 30 days after receiving such notice to consider the decision whether to elect a distribution and, if applicable, the mode in which he desires such distribution to be made, and (B) the Participant, after receiving such notice, affirmatively elects a distribution.

(c) Notwithstanding the foregoing, the Participant's Benefit Commencement Date shall be no later than the 60th day following the close of the Plan Year in which the Participant attains his Normal Retirement Age or has a Severance from Employment, whichever occurs last. In no event, however, shall a Participant's Benefit Commencement Date be later than his Required Beginning Date. In the event that the Participant defaults on an outstanding loan such that the unpaid balance becomes due and payable pursuant to Article X and the Participant fails to repay the loan in accordance with Subsection 10.4(d), that portion of the Participant's Account pledged as security for the loan shall be applied to repay the loan and shall be deemed distributed to the Participant within 60 days of the default, in which case the Participant may defer commencement of the balance of his Account as described above.

(d) If a distribution commences after a Participant's Benefit Commencement Date, any payments distributable in the form of an annuity shall be made retroactive to such date.

5.9 Death Benefits.

(a) (1) Except as provided in Subsection (b) of this Section, benefits payable under this Section 5.9 upon the death of a Participant shall be distributed in a single-sum payment as soon as is practicable following the Participant's death.

(2) Payment of death benefits that are payable in a single sum shall commence as soon as is practicable following the death of the Participant, provided, however, that if the Participant's death occurs prior to his Required Beginning Date, an individual beneficiary may elect to defer his Benefit Commencement Date, but not beyond December 31 of the calendar year following the year of the Participant's death, unless the beneficiary is the Participant's Spouse, in which case not beyond December 31 of the later of (1) the calendar year following the year of the Participant's death or (2) the calendar year in which the Participant would have attained Age 70½.

(b) The following rules shall apply solely with respect to a Participant's Former MPP Account, if any:

(1) If a Participant dies prior to his Benefit Commencement Date and has a surviving Spouse, the Participant's Spouse shall receive an annuity for the life of the Spouse that is based upon one hundred percent (100%) of the Participant's nonforfeitable interest in his Former MPP Account as of the date of his death. Such annuity may commence at any time following the date of the Participant's death, as elected in writing by the Spouse, but not later than the Participant's Normal Retirement Date or, if later, the first day of the month next following the Participant's death.

(2) A Participant may elect to waive the Spouse's annuity described in Paragraph (1) of this Subsection and elect to have his entire nonforfeitable interest in his Account paid in a single sum to a beneficiary or beneficiaries that may or may not include his Spouse. Any such election shall not be valid if the value of the nonforfeitable portion of the Participant's Account exceeds \$5,000 unless:

(A) the Participant's Spouse (or the Spouse's legal guardian if the Spouse is legally incompetent) executes a written instrument whereby such Spouse consents not to receive the Spouse's annuity described in Paragraph (1) of this Subsection and, if applicable, consents either to the specific beneficiary or beneficiaries designated by the Participant or to the Participant's right to designate any beneficiary or beneficiaries without further consent by the Spouse, provided further that such instrument acknowledges the effect of the election to which the Spouse's consent is being given and is witnessed by a notary public;

(B) the Participant (i) establishes to the satisfaction of the Committee that he has no Spouse or his Spouse cannot be located, or

(ii) furnishes a court order to the Committee establishing that the Participant is legally separated or has been abandoned (within the meaning of local law), unless a Qualified Domestic Relations Order pertaining to such Participant provides that the Spouse's consent must be obtained; or

(C) the Spouse has previously given consent in accordance with this Subsection and consented to the Participant's right to designate any beneficiary without further consent by the Spouse.

(3) The elections under Paragraphs (2) and (3) of this Subsection may be made at any time during the period beginning on the first day of the Plan Year in which the Participant attains Age 35 and ending on the earlier of the date of his death or his Benefit Commencement Date. In the case of a Participant who has a Severance from Employment prior to his attainment of Age 35, the period during which such election may be made with respect to benefits accrued as of his Severance from Employment shall begin no later than the date of his Severance from Employment. The consent of a Spouse in accordance with Paragraph (3) shall not be effective with respect to other Spouses of the Participant prior to the Participant's Benefit Commencement Date, and an election to which Subparagraph (b)(3) applies shall become void if the circumstances causing the consent of the Spouse not to be required no longer exist prior to the Participant's Benefit Commencement Date.

(4) The Spouse of a deceased Participant who is eligible to receive the Spouse's annuity described in Paragraph (1) or (2) may elect in writing to receive a single-sum payment in lieu of the Spouse's annuity.

(5) If a Participant dies before his Benefit Commencement Date and has no surviving Spouse, death benefits shall be paid to the beneficiary designated under Section 5.10 in the form of a single-sum payment as soon as practicable following the Participant's death.

(c) Qualified Military Service Death Benefit. If a Participant dies on or after January 1, 2007, while performing Qualified Military Service (within the meaning of section 414(u) of the Code) the Participant's Beneficiaries are entitled to any additional benefits (other than benefit accruals relating to the period of Qualified Military Service) provided under the Plan as if such Participant resumed and then terminated employment on account of death.

5.10 Beneficiary Designation.

(a) Except as provided herein, and subject to Section 5.9, a Participant may designate the beneficiary or beneficiaries who shall receive, on or after his death, his interest in the Fund, provided that the designation of a beneficiary under a joint and survivor annuity (with respect to a Participant's Former MPP Account, if any) shall be fixed and may not be changed on or after the date on which the annuity payments commence. Such designation shall be made by executing and filing with the Committee a written instrument in such form as may be prescribed by the Committee for that purpose. Except as provided herein, and subject to Section 5.9, the Participant may also revoke or change, at any time and from time to time, any beneficiary designations previously made. Such revocations and/or changes shall be made by executing and filing

with the Committee a written instrument in such form as may be prescribed by the Committee for that purpose. If a Participant names a trust as beneficiary, a change in the identity of the trustees or in the instrument governing such trust shall not be deemed a change in beneficiary.

(b) No designation, revocation, or change of beneficiaries shall be valid and effective unless and until filed with the Committee.

(c) A Participant who does not establish to the satisfaction of the Committee that he has no Spouse may not designate someone other than his Spouse to be his beneficiary unless:

(1) (A) such Spouse (or the Spouse's legal guardian if the Spouse is legally incompetent) executes a written instrument whereby such Spouse consents not to receive such benefit and consents either:

(i) to the specific beneficiary or beneficiaries designated by the Participant; or

(ii) to the Participant's right to designate any beneficiary without further consent by the Spouse;

(B) such instrument acknowledges the effect of the election to which the Spouse's consent is being given; and

(C) such instrument is witnessed by a notary public; or

(2) the Participant:

(A) establishes to the satisfaction of the Committee that his Spouse cannot be located; or

(B) furnishes a court order to the Committee establishing that the Participant is legally separated or has been abandoned (within the meaning of local law), unless a Qualified Domestic Relations Order pertaining to such Participant provides that the Spouse's consent must be obtained; or

(3) the Spouse has previously given consent in accordance with this Subsection and consented to the Participant's right to designate any beneficiary without further consent by the Spouse.

The consent of a Spouse in accordance with this Subsection (c) shall not be effective with respect to other Spouses of the Participant prior to the Participant's Benefit Commencement Date, and an election to which Paragraph (2) of this Subsection applies shall become void if the circumstances causing the consent of the Spouse not to be required no longer exist prior to the Participant's Benefit Commencement Date.

(d) If a Participant has no beneficiary under Subsection (a) of this Section, if the Participant's beneficiary(ies) predecease the Participant, or if the beneficiary(ies) cannot be located by the Committee, the interest of the deceased Participant shall be paid to the Participant's estate.

5.11 Rollover of Account to Other Plan.

(a) If (1) a Participant is entitled to receive a distribution from the Plan, either pursuant to this Article or pursuant to Article IX, or (2) a Spouse or former Spouse of a Participant is entitled to receive a distribution from the Plan pursuant to a Qualified Domestic Relations Order (as defined in Section 414(p) of the Code), such individual may direct the Committee to have the Trustee transfer (and the Trustee shall transfer) all or a portion (not less than \$500) of the amount to be distributed directly to:

(1) an individual retirement account described in Section 408(a) of the Code;

(2) an individual retirement annuity described in Section 408(b) of the Code (other than an endowment contract);

(3) a Roth individual retirement account described in Section 408A of the Code;

(4) a qualified defined contribution retirement plan, described in Section 401(a) of the Code, the terms of which permit the acceptance of rollover contributions;

(5) an annuity plan described in Section 403(a) of the Code;

(6) an annuity contract described in Section 403(b) of the Code; or

(7) an eligible plan described in Section 457(b) of the Code which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this Plan.

(b) In addition, if a Participant's non-Spouse beneficiary is entitled to receive a distribution from the Plan under Section 5.9, such beneficiary may direct the Committee to have the Trustee transfer (and the Trustee shall transfer) all or a portion (not less than \$500) of the amount to be distributed directly to:

(1) an individual retirement account described in Section 408(a) of the Code;

(2) an individual retirement annuity described in Section 408(b) of the Code (other than an endowment contract); or

(3) a Roth individual retirement account described in Section 408A of the Code.

(c) The Participant, Spouse or former Spouse must specify the name of the plan to which the Participant, Spouse or former Spouse wishes to have the amount transferred, plus such other information as may be requested by the Committee, on a form and in a manner prescribed by the Committee.

(d) Subsections (a) and (b) shall not apply to the following distributions:

(1) any distribution of Voluntary Contributions, unless such amounts are transferred directly to (A) an individual retirement account described in Section 408(a) of the Code, or (B) an individual retirement annuity described in Section 408(b) of the Code (other than an endowment contract) or (C) a qualified defined contribution plan described in Section 401(a) or 403(a) of the Code and which agrees to account separately for the Voluntary Contributions so transferred;

(2) any distribution if the total distributions paid or payable from the Plan to the same individual during the same calendar year are reasonably expected by the Committee to be less than \$200;

(3) that portion of any distribution after the Participant's Required Beginning Date that is required to be distributed to the Participant by the minimum distribution rules of Section 401(a)(9) of the Code;

(4) to the extent required by the Code and/or applicable Treasury regulations, and effective only as of the latest date permissible by the Code and/or such Treasury regulations, any distribution of Salary Reduction Contributions pursuant to Section 9.2;

(5) that portion of any distribution that is made pursuant to Section 9.3 (on account of financial hardship); or

(6) such other distributions as may be exempted by applicable statute or regulation from the requirements of Section 401(a)(31) of the Code.

5.12 Minimum Distribution Requirements.

(a) Notwithstanding anything contained herein to the contrary, all benefits payable pursuant to this Article shall comply with the requirements of Section 401(a)(9) of the Code (and accompanying Treasury regulations), and thus, the following rules shall apply to the extent required thereunder.

(b) General Rules.

(1) The requirements of this Section 5.12 will take precedence over any inconsistent provisions of the Plan.

(2) All distributions required under this Section 5.12 will be determined and made in accordance with the Treasury regulations under Section 401(a)(9) of the Code.

(3) Notwithstanding any provision of this Section 5.12 to the contrary, no distributions shall be made under this Section 5.12 for the 2009 Distribution Calendar Year ("2009 RMDs"), unless such a distribution is affirmatively elected by the Participant or his Designated Beneficiary. The Plan Administrator will establish reasonable procedures in order to provide such Participants and Designated Beneficiaries with the opportunity to elect to receive such distributions. In addition, notwithstanding any other provision of the Plan, a direct rollover will be offered for distributions that would be 2009 RMDs, but only if paid with an additional amount that is an eligible rollover distribution (within the meaning of Section 402(c)(4) of the Code), without regard to Section 401(a)(9)(H) of the Code.

(c) Time and Manner of Distribution.

(1) The Participant's entire interest will be distributed, or begin to be distributed, to the Participant no later than the Participant's Required Beginning Date.

(2) If the Participant dies before distributions begin, the Participant's entire interest will be distributed, or begin to be distributed, no later than as follows:

(A) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, then distributions to the surviving Spouse will begin by December 31 of the calendar year immediately following the calendar year in which the Participant died, or by December 31 of the calendar year in which the Participant would have attained age 70-1/2, if later.

(B) If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, then except as provided in Subsection 5.12(f), distributions to the designated beneficiary will begin by December 31 of the calendar year immediately following the calendar year in which the Participant died.

(C) If there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, the Participant's entire interest will be distributed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(D) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary and the surviving Spouse dies after the Participant but before distributions to the surviving Spouse begin, this Subsection 5.12(c)(2), other than Subsection 5.12(c)(2)(A), will apply as if the surviving Spouse were the Participant.

For purposes of this Subsection 5.12(c)(2) and Subsection 5.12(e), unless Subsection 5.12(c)(2)(D) applies, distributions are considered to begin on the Participant's Required Beginning Date. If Subsection 5.12(c)(2)(D) applies, distributions are considered to begin on the date distributions are required to begin to the surviving Spouse under Subsection 5.12(c)(2)(A). If distributions under an annuity purchased from an insurance company irrevocably commence to the Participant before the Participant's Required Beginning Date (or to the participant's surviving Spouse before the date distributions are required to begin to the surviving Spouse under Subsection 5.12(c)(2) (A)), the date distributions are considered to begin is the date distributions actually commence.

(3) Unless the Participant's interest is distributed in the form of an annuity purchased from an insurance company or in a single sum on or before the Required Beginning Date, as of the first Distribution Calendar Year distributions will be made in accordance with Subsections 5.12(d) and (e). If the Participant's interest is distributed in the form of an annuity purchased from an insurance company, distributions thereunder will be made in accordance with the requirements of Section 401(a)(9) of the Code and the Treasury regulations.

(d) Required Minimum Distributions During Participant's Lifetime.

(1) During the Participant's lifetime, the minimum amount that will be distributed for each Distribution Calendar Year is the lesser of:

(A) the quotient obtained by dividing the Participant's Account Balance by the distribution period in the Uniform Lifetime Table set forth in Section 1.401(a)(9)-9 of the Treasury regulations, using the Participant's age as of the Participant's birthday in the Distribution Calendar Year; or

(B) if the Participant's sole Designated Beneficiary for the Distribution Calendar Year is the Participant's Spouse, the quotient obtained by dividing the Participant's Account Balance by the number in the Joint and Last Survivor Table set forth in Section 1.401(a)(9)-9 of the Treasury regulations, using the Participant's and Spouse's attained ages as of the Participant's and Spouse's birthdays in the Distribution Calendar Year.

(2) Required minimum distributions will be determined under this Subsection 5.12(d) beginning with the first Distribution Calendar Year and up to and including the Distribution Calendar Year that includes the Participant's date of death.

(e) Required Minimum Distributions After Participant's Death.

(1) Death On or After Date Distributions Begin.

(A) If the Participant dies on or after the date distributions begin and there is a Designated Beneficiary, the minimum amount that will be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the longer of the remaining life expectancy of the Participant or the remaining Life Expectancy of the Participant's Designated Beneficiary, determined as follows:

(i) The Participant's remaining Life Expectancy is calculated using the age of the Participant in the year of death, reduced by one for each subsequent year.

(ii) If the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, the remaining Life Expectancy of the surviving Spouse is calculated for each Distribution Calendar Year after the year of the Participant's death using the surviving Spouse's age as of the Spouse's birthday in that year. For Distribution Calendar Years after the year of the surviving Spouse's death, the remaining Life Expectancy of the surviving Spouse is calculated using the age of the surviving Spouse as of the Spouse's birthday in the calendar year of the Spouse's death, reduced by one for each subsequent calendar year.

(iii) If the Participant's surviving Spouse is not the Participant's sole Designated Beneficiary, the Designated Beneficiary's remaining Life Expectancy is calculated using the age of the Beneficiary in the year following the year of the Participant's death, reduced by one for each subsequent year.

(B) If the Participant dies on or after the date distributions begin and there is no Designated Beneficiary as of September 30 of the year after the year of the Participant's death, the minimum amount that will be distributed for

each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's account balance by the Participant's remaining life expectancy calculated using the age of the Participant in the year of death, reduced by one for each subsequent year.

(2) Death Before Date Distributions Begin.

(A) Except as provided in Subsection 5.12(f), if the Participant dies before the date distributions begin and there is a Designated Beneficiary, the minimum amount that will be distributed for each Distribution Calendar Year after the year of the Participant's death is the quotient obtained by dividing the Participant's Account Balance by the remaining Life Expectancy of the Participant's Designated Beneficiary, determined as provided in Subsection 5.12(e)(1).

(B) If the Participant dies before the date distributions begin and there is no Designated Beneficiary as of September 30 of the year following the year of the Participant's death, distribution of the Participant's entire interest will be completed by December 31 of the calendar year containing the fifth anniversary of the Participant's death.

(C) If the Participant dies before the date distributions begin, the Participant's surviving Spouse is the Participant's sole Designated Beneficiary, and the surviving Spouse dies before distributions are required to begin to the surviving Spouse under Subsection 5.12(c)(2)(A), this Subsection 5.12(e)(2) will apply as if the surviving Spouse were the Participant.

(f) If the Participant dies before distributions begin and there is a Designated Beneficiary, distribution to the Designated Beneficiary is not required to begin by the date specified in Subsection 5.12(c)(2), but the Participant's entire interest will be distributed to the Designated Beneficiary by December 31 of the calendar year containing the fifth anniversary of the Participant's death. If the Participant's sole Designated Beneficiary and the surviving Spouse dies after the Participant but before the distributions to either the Participant or the surviving Spouse begin, this election will apply as if the surviving Spouse were the Participant.

(g) Definitions. Unless a different meaning is plainly implied by the context, the following terms as used in this Section 5.12 shall have the following meanings:

"Designated Beneficiary" means the individual who is designated as the beneficiary under Section 5.10 of the Plan and is the designated beneficiary under Section 401(a)(9) of the Internal Revenue Code and Section 1.401(a)(9)-1, Q&A-4, of the Treasury regulations.

"Distribution Calendar Year" means a calendar year for which a minimum distribution is required. For distributions beginning before the Participant's death, the first Distribution Calendar Year is the calendar year immediately preceding the calendar year which contains the Participant's Required Beginning Date. For distributions beginning after the Participant's death, the first Distribution Calendar Year is the calendar year in which distributions are required to begin under Subsection 5.12(c)(2). The required minimum distribution for the Participant's first Distribution

Calendar Year will be made on or before the Participant's Required Beginning Date. The required minimum distribution for other Distribution Calendar Years, including the required minimum distribution for the Distribution Calendar Year in which the Participant's Required Beginning Date occurs, will be made on or before December 31 of that Distribution Calendar Year.

"Life Expectancy" means life expectancy as computed by use of the Single Life Table in Section 1.401(a)(9)-9 of the Treasury regulations.

"Participant's Account Balance" means the balance in the Participant's Account as of the last valuation date in the calendar year immediately preceding the Distribution Calendar Year (valuation calendar year) increased by the amount of any contributions made and allocated or forfeitures allocated to the account balance as of dates in the valuation calendar year after the valuation date and decreased by distributions made in the valuation calendar year after the valuation date. The account balance for the valuation calendar year includes any amounts rolled over or transferred to the plan either in the valuation calendar year or in the Distribution Calendar Year if distributed or transferred in the valuation calendar year.

"Required Beginning Date" means the date specified in the definition of "Required Beginning Date" set forth in Article I of the Plan.

(h) Nothing contained in this Section 5.12 shall be construed as providing any optional form of payment or other right that is not available under the other Sections of the Plan.

ARTICLE VI

VESTING

6.1 Nonforfeitable Amounts.

(a) A Participant shall have a 100% nonforfeitable interest at all times in his Account, except for his Company Match Account, Former MPP Account, 1% Company Contribution Account and Discretionary Contribution Account, each of which shall vest in accordance with Subsection (b) hereof.

(b) (1) Except as provided in Appendix A, a Participant who is credited with one or more Hours of Service as an Employee on or after December 1, 1988 shall have a nonforfeitable interest in his Former MPP Account, and in his Company Match Account, determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 3 years	0 percent
3 years	30 percent
4 years	40 percent
5 years	60 percent
6 years	80 percent
7 years or more	100 percent

(2) (A) With respect to that portion of his 1% Company Contribution Account and Discretionary Contribution Account that is attributable to contributions for Plan Years ending on or before December 31, 2006, a Participant shall have a nonforfeitable interest determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 5 years	0 percent
5 years or more	100 percent

(B) With respect to that portion of his 1% Company Contribution Account and Discretionary Contribution Account that is attributable to contributions for Plan Years beginning on or after January 1, 2007, a Participant shall have a nonforfeitable interest determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 3 years	0 percent
3 years or more	100 percent

(3) Notwithstanding the foregoing, a Participant shall have a 100% nonforfeitable interest in his Company Match Account, Former MPP Account, 1% Company Contribution Account and Discretionary Contribution Account if, while an Employee, he attains his Normal Retirement Age, dies, or suffers a Total Disability.

6.2 Years of Service for Vesting.

(a) For the purposes of this Article, an Employee shall be credited with a Year of Service for each calendar year (including years before the Effective Date) during which he is credited with 1,000 or more Hours of Service.

(b) Notwithstanding any provision of this Plan to the contrary, an Employee shall not be credited with any Years of Service for service prior to the date on which the vesting rules contained in ERISA and in the Code, as amended by ERISA, became effective with respect to the Plan, if such service would have been disregarded under the rules of the Plan with regard to breaks in service as in effect on the applicable date.

6.3 Breaks in Service and Loss of Service.

(a) An Employee's Years of Service shall be canceled if he incurs a Break in Service before his Normal Retirement Date and at a time when (1) he has no nonforfeitable interest in any of his Accounts, other than his Voluntary Contribution, Rollover, After-Tax Rollover, or Employee Prior Accounts, or (2) he has no Account under the Plan.

(b) Except as provided in Subsections (c) and (d) of this Section, an Employee or former Employee shall incur a Break in Service in any calendar year in which he is not credited with more than 500 Hours of Service.

(c) If an Employee is absent for one or more of the following reasons, then, to the extent he is not otherwise credited with Hours of Service with respect to such absence, he shall be credited with an Hour of Service, solely for purposes of Subsection (b) of this Section, for each Hour of Service with which he would have been credited if he had continued to be actively employed during the period of absence due to:

- (1) layoff for a period not in excess of one year;
- (2) leave of absence that is protected under the Family and Medical Leave Act of 1993; or
- (3) leave of absence for any other reason with the approval of the Committee for a period not in excess of one year, unless such period is extended by the Committee.

(d) If an Employee is absent from work by reason of pregnancy, childbirth, or placement in connection with adoption, or for purposes of the care of such Employee's child immediately after birth or placement in connection with adoption, such Employee shall be credited, solely for purposes of Subsection (b) of this Section, with the Hours of Service with which such Employee would have been credited but for the absence or, if such hours cannot be determined, with eight Hours of Service

per normal workday. The total number of hours to be treated as Hours of Service under this Subsection shall not exceed 501. The hours described in this Subsection shall be credited either for the calendar year in which the absence from work begins, if the Employee would be prevented from incurring a Break in Service in such calendar year because the period of absence is treated as Hours of Service under this Subsection or, in any other case, for the calendar year next following the one in which the absence from work begins.

6.4 Restoration of Service. The Years of Service of an Employee whose Years of Service have been canceled pursuant to Section 6.3 shall be restored to his credit if he thereafter completes an Hour of Service at a time when the number of his consecutive Breaks in Service is less than the greater of (a) the number of Years of Service to his credit when the first such Break in Service occurred, or (b) five.

6.5 Forfeitures and Restoration of Forfeited Amounts upon Reemployment. Except as otherwise provided in Appendix A:

(a) For any Participant who has a Severance from Employment, his Company Match Account, Former MPP Account, 1% Contribution Account, and Discretionary Contribution Account shall be closed, and the forfeitable amount held therein shall be forfeited as of the earlier of:

(1) the date on which he receives or is deemed to receive a distribution of his entire nonforfeitable interest in his Account, which is less than 100%; or

(2) the last day of the Plan Year in which he incurs his fifth consecutive one-year Break in Service.

For purposes of this Subsection (a), a Participant who has a Severance from Employment at a time when his nonforfeitable interest in the Plan is zero shall be deemed to have received a distribution described in Paragraph (1) of this Subsection on the date of such Severance from Employment.

(b) Amounts forfeited from a Participant's Company Match Account, Former MPP Account, 1% Company Contribution Account, and Discretionary Contribution Account under Subsection (a) of this Section shall be treated as Applied Forfeitures and used to reduce future Safe Harbor Matching Contributions and/or Discretionary Contributions, in such manner as shall be determined by the Committee. Effective January 1, 2008, such forfeitures may also be treated as Applied Forfeitures to offset Plan expenses and fees, in such manner as shall be determined by the Committee.

(c) If a Participant who has received (or is deemed to have received) a distribution described in Paragraph (a)(1) of this Section, whereby any part of his Account has been forfeited, again becomes a Covered Employee prior to incurring five consecutive one-year Breaks in Service, the amount so forfeited shall be restored to his Company Match Account, Former MPP Account, 1% Company Contribution Account, and Discretionary Contribution Account, as appropriate, if and only if he repays the full amount of such distribution (if any) prior to the earlier of (1) the fifth anniversary of the date on which he subsequently becomes a Covered Employee or (2) the first date the Participant incurs five consecutive one-year Breaks in Service following the date of

the distribution; provided, however, that a Participant described in the preceding sentence who is deemed to receive a distribution of his entire nonforfeitable interest shall be deemed to repay such distribution on the date he again becomes a Covered Employee. Amounts restored under this Subsection shall be charged against the following amounts in the following order of priority: (1) forfeitures for the Plan Year, (2) income or gains to the Plan, and (3) Company contributions for the Plan Year. If the foregoing amounts are insufficient, the Participating Company by whom such Participant is reemployed shall make any additional contribution necessary to accomplish the restoration.

(d) If a Participant has had five consecutive one-year Breaks in Service and again becomes a Covered Employee, the amount forfeited under Subsection (a) of this Section shall not be restored to his Company Match Account, Former MPP Account, 1% Company Contribution Account, or Discretionary Contribution Account under any circumstances.

ARTICLE VII

TREATMENT OF RETURNING VETERANS

7.1 Applicability and Effective Date. The rights of any Returning Veteran who resumes employment with a Participating Company shall be modified as set forth in this Article.

7.2 Eligibility to Participate. For purposes of Section 2.3:

(a) A Returning Veteran who was an Eligible Employee immediately prior to his Qualified Military Service shall be deemed to have remained an Eligible Employee throughout his Qualified Military Service.

(b) A Returning Veteran who would have become an Eligible Employee during the period of his Qualified Military Service, but for the resulting absence from employment, shall be deemed to have become an Eligible Employee as of the date he would have become an Eligible Employee if he had not entered into Qualified Military Service.

7.3 No Break in Service. A Returning Veteran shall be deemed not to have any Break in Service on account of his Qualified Military Service.

7.4 Vesting Credit. A Returning Veteran's Years of Service shall be determined under Section 6.2, except that with respect to any period of Qualified Military Service, he shall be credited with the Hours of Service with which he would have been credited had he remained an Employee.

7.5 Restoration of Salary Reduction, Catch-Up, and/or Voluntary Contributions.

(a) Each Returning Veteran who, during his period of Qualified Military Service, would have been eligible to make Salary Reduction, Catch-Up, and/or Voluntary Contributions shall be permitted to contribute an amount equal to the Salary Reduction, Catch-Up, and/or Voluntary Contributions that he could have made during such absence from employment. Such "make-up" contributions shall be made during the period that begins with his reemployment by the Participating Company and ends with (1) the expiration of a period of five years or, (2) if shorter, a period of three times the period of Qualified Military Service.

(b) Any make-up contributions described in Subsection (a) hereof shall be in addition to those Salary Reduction, Catch-Up, and/or Voluntary Contributions that the Participant may elect to make pursuant to Section 3.1.

7.6 Determination of Compensation. For purposes of determining the amount of any make-up contributions under Section 7.5 or of any contributions described in Section 7.8, and for applying the limits of Section 3.8, a Participant's Compensation during any period of Qualified Military Service shall be deemed to equal either:

(a) the Compensation he would have received but for such Qualified Military Service, based on the rate of pay he would have received from a Participating Company, or

(b) if the amount described in Subsection (a) above is not reasonably certain, his average Compensation from a Participating Company during the 12-month period immediately preceding the Qualified Military Service (or, if shorter, the period of employment immediately preceding the Qualified Military Service). Such amount shall be adjusted as necessary to reflect the length of the Participant's Qualified Military Service.

7.7 Restoration of Safe Harbor Matching Contributions. If a Returning Veteran contributes "make-up" Salary Reduction and/or Voluntary Contributions pursuant to Section 7.5, the Participating Company shall contribute on his behalf the related Safe Harbor Matching Contributions that it would have made under Section 2.6 if such Salary Reduction and/or Voluntary Contributions had been made in the year to which they relate. Such Safe Harbor Matching Contributions shall not include the earnings that would have accrued on such amount during the period of Qualified Military Service.

7.8 Restoration of 1% Company Contributions and Discretionary Contributions. In addition to the contributions described in Section 7.7, a Participating Company shall contribute on behalf of each Returning Veteran (who is an Employee of such Participating Company) an amount equal to the Discretionary Contributions, if any, that it would have made on his behalf under Sections 3.5 if he had remained an active Employee during the period of his Qualified Military Service. The Company shall also contributed on behalf of each Returning Veteran (who is an Employee of such Participating Company) an amount equal to the 1% Company Contributions, if any, that would have been made on his behalf under the terms of the Plan as applicable on December 31, 2008, if he had remained an active Employee during the period of his Qualified Military Service.

7.9 Application of Certain Limitations.

(a) For purposes of applying the limitations of Section 3.8, any make-up contributions described in Section 7.5 (other than Catch-Up Contributions), any related Safe Harbor Matching Contributions described in Section 7.7, and any 1% Company Contributions and Discretionary Contributions described in Section 7.8 shall be treated as contributions for the Limitation Year to which they relate, rather than the Limitation Year in which they are actually made.

(b) For purposes of applying the limitation of Subsection 3.1(b), any such make-up contributions described in Section 7.5, which are Salary Reduction Contributions, shall be treated as contributions for the calendar year to which they relate, rather than the calendar year in which they are actually made.

(c) For purposes of applying the limitations of Article XI, any make-up contributions described in Section 7.5, related Safe Harbor Matching Contributions described in Section 7.7, and any 1% Company Contributions and Discretionary Contributions described in Section 7.8 shall be disregarded, both for the Plan Year to which the contributions relate and for the Plan Year in which they are actually made.

7.10 Administrative Rules and Procedures. The Committee shall establish such rules and procedures as it deems necessary or desirable to implement the provisions of this Article, provided that they are not in violation of the Uniformed Services Employment and Reemployment Rights Act of 1994, any regulations thereunder, or any other applicable law.

ARTICLE VIII
ROLLOVER CONTRIBUTIONS

8.1 Rollover Contributions.

(a) Subject to the restrictions set forth in Subsection (b), a Covered Employee may transfer or have transferred directly to the Fund all or a portion of his interest in:

(1) a qualified plan described in Section 401(a) and 403(a) of the Code, including after-tax employee contributions;

(2) an annuity contract described in Section 403(b) of the Code, excluding after-tax employee contributions;

(3) an eligible plan under Section 457(b) of the Code that is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state; or

(4) an individual retirement account or annuity described in Section 408(a) or 408(b) of the Code that is eligible to be rolled over, to the extent that it would otherwise be included in gross income.

Such individual retirement account shall not contain nondeductible contributions made by the Employee while he was a participant in such plans.

(b) The Trustee shall not accept a distribution from any other qualified retirement plan or from an individual retirement account unless the following conditions are met:

(1) (A) the distribution being transferred must come directly from the fiduciary of the plan of the former employer; or

(B) it must come from the Employee within 60 days after the Employee receives a distribution from such other qualified retirement plan or individual retirement account and must comply with the provisions of Section 402(c), 403(a)(4), or 408(d)(3) of the Code, whichever applies;

(2) distributions from a plan for a self-employed person shall not be transferred to this Plan, unless the transfer is directly to the Fund from the funding agent of the distributing plan;

(3) the interest being transferred shall not include assets from any plan to the extent that the Committee determines that the transfer of such interest (A) would impose upon this Plan requirements as to form of distribution that would not otherwise apply hereunder, or (B) would otherwise result in the elimination of Code Section 411(d)(6) protected benefits, or (C) would cause the Plan to be a direct or indirect transferee of a plan to which the joint and survivor annuity requirements of Sections 401(a)(11) and 417 of the Code apply; and

(4) the interest being transferred shall not contain nondeductible contributions made to the distributing plan by the Employee unless the transfer to the Fund is directly from the funding agent of the distributing plan.

8.2 Vesting and Distribution of Rollover Account.

(a) The distributions transferred by or for a Covered Employee from another qualified retirement plan or from an individual retirement account shall be credited to the Employee's Rollover Account or After-Tax Rollover Account, as appropriate. An Employee shall be fully vested at all times in his Rollover Account and After-Tax Rollover Account.

(b) An Employee's Rollover Account and After-Tax Rollover Account shall be distributed as otherwise provided under the Plan.

ARTICLE IX
WITHDRAWALS

9.1 General. Each Participant may withdraw, by Written Election, his vested interest in the Fund in the manner, in the amount, and at the time provided in this Article.

9.2 Withdrawals Not Subject to Section 401(k) Restrictions.

(a) An Employee may withdraw without penalty, up to the total value of the amount in the following Accounts:

- (1) his Company Prior Match Account;
- (2) his Employee Prior Account;
- (3) his Voluntary Unmatched Contribution Account;
- (4) his Voluntary Contribution Account, to the extent attributable to Voluntary Matched Contributions that were contributed at least 24 months prior to the date of withdrawal; and
- (5) his After-Tax Rollover Account.

(b) Withdrawals under this Section shall be charged against a Participant's Accounts in the following order of priority:

- (1) the Participant's After-Tax Rollover Account, less any amounts previously withdrawn therefrom;
- (2) (A) the portion of the Participant's Voluntary Matched Contribution Account and Voluntary Unmatched Contribution Account, if any, that consists of the Voluntary Contributions the Participant contributed before January 1, 1987, if any, less any amounts previously withdrawn therefrom;
- (B) the balance of the Participant's Voluntary Matched Contribution Account and Voluntary Unmatched Contribution Account that is eligible for withdrawal under this Section after the application of Subparagraph (A) of this Paragraph, if any, less any amounts previously withdrawn therefrom;
- (3) the Participant's Employee Prior Account, less any amounts previously withdrawn therefrom; and
- (4) the Participant's Company Prior Match Account, less any amounts previously withdrawn therefrom.

9.3 Withdrawals Subject to Section 401(k) Restrictions.

(a) In addition to the withdrawals permitted under Section 9.2, a Participant may withdraw, under the rules set forth in Subsections (b) through (e) of this Section, the following amounts:

- (1) his 401(k) Account;
- (2) his Catch-Up Account;

(3) his Old Plan Account;
(4) his Prior Plan Rollover Account;
(5) his Rollover Account;
(6) the vested portion of his 50% Company Match Account;
(7) the vested portion of his Company Match Account;
(8) the vested portion of his Company Prior Match Account; and
(9) the vested portion of his Safe Harbor Match Account.

(b) A withdrawal under Subsection (a) of this Section shall be permitted only if the Committee finds that:

(1) it is made on account of immediate and heavy financial need (as defined in Subsection (c) of this Section) of the Participant; and

(2) it is necessary (as defined in Subsection (d) of this Section) to satisfy such immediate and heavy financial need.

(c) A withdrawal under Subsection (a) will be deemed to be on account of an immediate and heavy financial need if the Participant requests such withdrawal on account of:

(1) expenses for medical care described in Section 213(d) of the Code and previously incurred by the Participant, his Spouse, or any of the Participant's dependents (as defined in Section 152 of the Code) or necessary for such individuals to obtain such medical care;

(2) costs directly related to the purchase (excluding mortgage payments) of a principal residence of the Participant;

(3) the payment of tuition, related educational fees, and room and board expenses, for the next 12 months of post-secondary education for the Participant, his Spouse, children, or dependents (as defined in Section 152 of the Code, without regard to Sections 152(b)(1), (b)(2) and (d)(1)(B) of the Code);

(4) the need to prevent the eviction of the Participant from his principal residence or foreclosure on the mortgage of his principal residence;

(5) the payment of burial or funeral expenses for the Participant's deceased parent, Spouse, children or dependents (as defined in Section 152 of the Code, without regard to Section 152(d)(1)(B) of the Code);

(6) expenses for the repair of damage to the Participant's principal residence that would qualify for the casualty deduction under Section 165 of the Code (determined without regard to whether the loss exceeds ten percent (10%) of adjusted gross income); or

(7) such other circumstances or events as may be prescribed by the Secretary of the Treasury or his delegate.

(d) A withdrawal under Subsection (a) shall be deemed to be necessary if:

(1) the amount of the withdrawal does not exceed the amount of the Participant's immediate and heavy financial need, including any amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the withdrawal;

(2) the Participant has obtained all currently permissible distributions (other than hardship distributions) and non-taxable loans, if any, under this and all other plans maintained by the Participating Company and all Affiliated Companies; and

(3) the Participant agrees in writing to be bound by the rules of Subsection (e).

(e) If a Participant who makes a withdrawal under Subsection (a), or who withdraws any elective deferrals under any other qualified retirement plan maintained by a Participating Company or Affiliated Company, which other plan conditions such withdrawal upon the Participant's being subject to rules similar to those stated in this Subsection (a) and Subsection (d), such Participant may not make Salary Reduction Contributions, Catch-Up Contributions, or Voluntary Contributions under this Plan or employee contributions (other than mandatory contributions under a defined benefit plan) or elective deferrals under any other qualified or non qualified plan of deferred compensation (which does not include any health or welfare plan, including a health or welfare plan that is part of a cafeteria plan described in Section 125 of the Code) maintained by a Participating Company or Affiliated Company for a period of six months commencing on the date of his receipt of the withdrawal.

(f) Any withdrawal under this Section shall be satisfied by diminishing the Participant's Accounts in the order set forth in Subsection (a) hereof.

9.4 Withdrawals On and After Attainment of Age 59½. Upon his attainment of Age 59½, a Participant may withdraw up to the vested portion in his Account (exclusive of the Former MPP Account and the Company Basic Account), less amounts previously withdrawn therefrom.

9.5 Withdrawals On and After Attainment of Age 65. Upon his attainment of age 65, a Participant may withdraw up to the full value of his Company Basic Account, less amounts previously withdrawn therefrom.

9.6 Amount and Payment of Withdrawals. The amount of any withdrawal will be determined on the basis of the value of the Participant's Account as of the Valuation Date coincident with or immediately preceding the date of the withdrawal. Any withdrawal requested under this Section shall be paid as soon as is practicable following the Committee's determination that the requested withdrawal complies with the terms and conditions set forth in this Article.

9.7 Withdrawals Not Subject to Replacement. A Participant may not replace any portion of his Accounts withdrawn under this Plan.

9.8 Pledged Amounts. No amount that has been pledged as security for a loan under Article X may be withdrawn under this Article.

9.9 Investment Medium to be Charged with Withdrawal. Distribution of any withdrawal under this Article will be made out of the Participant's interest in the various Investment Media in proportion to the Participant's share in such Investment Media.

ARTICLE X

LOANS TO PARTICIPANTS

10.1 Loan Application. Each Participant who is an Employee of a Participating Company and any other Participant or beneficiary who is a party in interest as defined in ERISA may apply for a loan from the Plan. All applications shall be made to the Committee on forms which it prescribes, and the Committee shall rule upon such applications in a uniform and nondiscriminatory manner in accordance with the rules and guidelines established in this Article and in the Plan's Loan Policy, as the same may be amended from time to time.

10.2 Loan Approval.

(a) No more than two applications by a Participant for a loan shall be approved during any calendar year. A minimum of one month must pass between the dates that one loan is paid off and a subsequent loan is applied for.

(b) The Committee shall have the right to reject a loan application if the Participant has the present intention to take a personal leave of absence during the period of loan repayment or on the basis of a Participant's creditworthiness and financial need or such other factors as would be considered in a normal commercial setting by an entity in the business of making loans and as the Committee determines necessary to safeguard the Fund.

(c) The Committee shall not approve a loan to a Participant who is a party to a domestic relations order until the Committee has determined that either (1) such order is a Qualified Domestic Relations Order as defined in Section 414(p) of the Code and has segregated or distributed, as the case may be, the Alternate Payee's portion of the Account, or (2) such order is not a Qualified Domestic Relations Order, and has so notified the Participant and Alternate Payee.

10.3 Amount of Loan.

(a) In no event shall a Participant be permitted to have more than one loan outstanding at any time from this Plan. The minimum amount of any loan shall be \$1,000. In no event shall the loan amount exceed fifty percent (50%) of the value of the vested portion of the Participant's Account (exclusive of his 1% Company Contribution Account and Discretionary Contribution Account, if any) determined as of the Valuation Date immediately preceding the date on which the loan application is received by the Committee.

(b) The amount of any loan, when added to the amount of a Participant's outstanding loans under the Plan and all other plans qualified under Section 401(a) of the Code which are sponsored by a Participating Company or Affiliated Company, shall not exceed the lesser of:

(1) \$50,000, reduced by the excess (if any) of:

(A) the Participant's highest outstanding balance of loans during the one-year period ending on the day before the date on which such loan is made to the Participant, over

(B) the outstanding balance of loans made to the Participant on the date such loan is made to the Participant; or

(2) fifty percent (50%) of the value of the Participant's nonforfeitable Account (exclusive of his 1% Company Contribution Account and Discretionary Contribution Account, if any).

10.4 Terms of Loan.

(a) The interest rate on loans shall be: (1) determined by the Committee, (2) at least commensurate with rates charged for similar loans by entities in the business of making loans, and (3) adjusted from time to time as circumstances warrant. Security for each loan granted pursuant to this Article shall be, to the extent necessary, the currently unpledged portion of, in the following order, the Participant's:

- (A) Employee Prior Account;
- (B) Voluntary Unmatched Account;
- (C) After-Tax Rollover Account;
- (D) Voluntary Matched Account;
- (E) Old Plan Account;
- (F) Rollover Account;
- (G) Prior Plan Rollover Account;
- (H) Company Prior Match Account;
- (I) Company Match Account;
- (J) Safe Harbor Match Account (exclusive of Safe Harbor Matching Contributions allocated within 24 months prior to the date of application of the security, unless the Participant has been a Participant for a period of at least 60 months or has had a Severance from Employment);
- (K) Company Match Union Account;
- (L) 50% Company Match Account;
- (M) Company Basic Account;
- (N) 401(k) Account;
- (O) Catch-Up Account;
- (P) Former MPP Account;
- (Q) Qualified Non-Elective Contribution Account;
- (R) 1% Company Contribution Account; and
- (S) Discretionary Contribution Account.

In no event shall more than fifty percent (50%) of the Participant's vested Account as of the date the loan is made be used as security for the loan. In its sole discretion, the Committee may require such additional security as it deems necessary. Notwithstanding the foregoing, a Participant's Former MPP Account may not be used as security for a loan unless:

(1) (A) the Participant's Spouse consents in writing to the use of the Participant's Former MPP Account as security for the loan within the 90-day period ending on the date the Participant receives the loan;

(B) such consent acknowledges its own effect;

and

(C) such consent is witnessed by a notary public; or

(2) the Participant establishes to the satisfaction of the Committee that he has no Spouse or that his Spouse's consent is not required because of such circumstances as are prescribed in applicable governmental regulations.

(b) Each loan shall be evidenced by the Participant's execution of a personal demand note on such form as shall be supplied by the Committee. Each such note shall specify that, to the extent repayment is not demanded sooner, repayment shall be included in installments of 12, 24, 36, 48, 54, or 60 months from the date on which the loan is distributed. All loans from the Plan shall be non-renewable. Each note shall also specify the interest rate as determined by the Committee at the time the loan is approved.

(c) All loans shall be repaid in approximately equal installments not less frequently than quarterly through payroll deductions or in such other manner as the Committee may determine, although loan repayments may be suspended during a leave of absence, in accordance with the terms set forth in the plan's Loan Policy. A Participant may repay the outstanding balance of any loan in one lump sum at any time by notifying the Committee of his intent to do so and by forwarding to the Committee payment in full of the then outstanding balance, plus interest accrued to the date of payment. The amount of principal and interest repaid by a Participant shall be credited to a Participant's Account as each repayment is made.

(d) If, and only if:

(1) the Participant dies;

(2) the Participant (other than a Participant who continues to be a party in interest) has a Severance from Employment;

(3) the Compensation of a Participant who is an Employee of a Participating Company is discontinued or decreased below the amount necessary to amortize the loan;

(4) the loan is not repaid by the time the note matures;

(5) the Participant fails to pay any installment of the loan when due and the Committee elects to treat such failure as default; or

(6) any other event occurs which the Committee, in its sole discretion, believes may jeopardize the repayment of the loan;

before a loan is repaid in full, the unpaid balance thereof, with interest due thereon, shall become immediately due and payable. The Participant (or his beneficiary, in the event of the Participant's death) may satisfy the loan by paying the outstanding balance of the loan within 30 days. If the loan and interest are not repaid within the time specified, the Committee shall satisfy the indebtedness from the amount of the Participant's vested interest in his Account as provided in Section this 10.4 before making any payments otherwise due hereunder to the Participant or his beneficiary.

10.5 Enforcement. The Committee shall give written notice to the Participant (or his beneficiary in the event of the Participant's death) of an event of default described in Subsection 10.4(d). If the loan and interest are not paid within thirty (30) days of the date of the notice, but in no event later than the last day of the calendar quarter next following the calendar quarter in which the Participant failed to pay any loan installment, if applicable, the amount of the Participant's vested interest in his Account shall be reduced by the amount of the unpaid balance of the loan, with interest due thereon, and the Participant's indebtedness shall thereupon be discharged to the extent of the reduction. If the Participant has not had a Severance from Employment, the following restrictions apply to any such reduction of his Account:

(a) Except as provided in Subsections (b), (c) and (d), his 401(k) Account, Safe Harbor Match Account, Rollover Account, Catch-Up Account, Company Basic Account, Company Match Account, 50% Company Match Account, Discretionary Contribution Account, Old Plan Account and Prior Plan Rollover Account shall be reduced only if and at such time as the Participant is entitled to a distribution of such amounts under Article V or, if applicable, a withdrawal of such amounts under Article IX.

(b) Safe Harbor Matching Contributions allocated fewer than 24 months prior to the date of the reduction to the Participant's Account shall not be reduced unless he has been a Participant for a period of at least 60 months.

(c) Notwithstanding Subsection 10.5(a), Company Basic Contributions that the Committee elected to take into account in the numerator of the Participant's "contribution percentage" (as defined in the Plan as in effect on June 30, 2000) shall not be reduced.

(d) No reductions shall be made from a Participant's Discretionary Contribution Account or 1% Company Contribution Account.

10.6 Additional Rules. The Committee has established a Loan Policy, and may establish additional rules relating to Participant loans under the Plan, which may be amended from time to time, and which shall be deemed incorporated into, and part of the terms of, the Plan. In the event of a conflict between the terms of this Article and the terms of the Loan Policy, the Loan Policy shall control.

ARTICLE XI

PROVISIONS RELATING TO TOP-HEAVY PLANS

11.1 Top-Heavy Rules to Control. Notwithstanding anything contained herein to the contrary, if for any Plan Year the Plan is a 'top-heavy plan', as determined pursuant to Section 416 of the Code, then the Plan must meet the requirements of this Article XI for such Plan Year. For this purpose the term 'top-heavy plan' shall not include a plan which consists solely of (a) a cash or deferred arrangement which meets the requirements of Section 401(k)(12) or 401(k)(13) of Code, and (b) matching contributions with respect to which the requirements of Section 401(m)(11) or 401(m)(12) of the Code.

11.2 Top-Heavy Plan Definitions. Unless a different meaning is plainly implied by the context, the following terms as used in this Article XI shall have the following meanings:

"Accrued Benefit" means the account balances or accrued benefits of an Employee, calculated pursuant to Section 11.3.

"Determination Date" means, with respect to any particular Plan Year of this Plan, the last day of the preceding Plan Year. In addition, Determination Date shall mean, with respect to any particular plan year of any plan (other than this Plan) in a Required Aggregation Group or a Permissive Aggregation Group, the last day of the plan year of such plan which falls within the same calendar year as the Determination Date for this Plan.

"Key Employee" means any Employee or former Employee (including any deceased Employee) who at any time during the Plan Year that includes the Determination Date was (1) an officer of a Participating Company having annual Compensation greater than the amount set forth in Section 416(i)(1) of the Code (as adjusted for inflation in accordance therewith), (2) a 5% owner of a Participating Company, or (3) a 1% owner of a Participating Company having annual Compensation of more than \$150,000. The determination of who is a Key Employee shall be made in accordance with Section 416(i)(1) of the Code and the applicable regulations and other guidance of general applicability issued thereunder.

"Non-Key Employee" means any Employee or former Employee (or any Beneficiary of such Employee or former Employee, as the case may be) who is not considered to be a Key Employee with respect to this Plan.

"Permissive Aggregation Group" means any group of plans which contains all plans in the Required Aggregation Group, plus one or more plans of the Participating Company or an Affiliated Company (as selected by the Participating Company) which are not part of the Required Aggregation Group, but which satisfy the requirements of Sections 401(a)(4) and 410 of the Code when considered together with the Required Aggregation Group.

"Required Aggregation Group" means any group of plans which contains (1) each plan of the Participating Company or an Affiliated Company in which a Key Employee is a participant, and (2) each other plan of the Participating Company or

an Affiliated Company which enables any plan described in (1) above to meet the requirements of Section 401(a)(4) or Section 410 of the Code.

11.3 Calculation of Accrued Benefit.

(a) An Employee's Accrued Benefit shall be equal to:

(1) With respect to the Plan or any other defined contribution plan (other than a defined contribution pension plan) in a Required Aggregation Group or a Permissive Aggregation Group, the Employee's account balances under the respective plan, determined as of the most recent plan valuation date within a 12-month period ending on the Determination Date, including contributions actually made after the valuation date but before the Determination Date (and, in the first plan year of a plan, also including any contributions made after the Determination Date which are allocated as of a date in that first plan year).

(2) With respect to any defined contribution pension plan in a Required Aggregation Group or a Permissive Aggregation Group, the Employee's account balances under the plan, determined as of the most recent plan valuation date within a 12-month period ending on the Determination Date, including contributions which have not actually been made, but which are due to be made as of the Determination Date.

(3) With respect to any defined benefit plan in a Required Aggregation Group or a Permissive Aggregation Group, the present value of the Employee's accrued benefits under the plan, determined as of the most recent plan valuation date within a 12-month period ending on the Determination Date, pursuant to the actuarial assumptions used by such plan, and calculated as if the Employee terminated employment under such plan as of the valuation date (except that, in the first plan year of a plan, a current Participant's estimated Accrued Benefit as of the Determination Date shall be taken into account). The accrued benefit of any Employee (other than a Key Employee) shall be determined (A) under the method which is used for accrual purposes for all plans of the Participating Company and any Affiliated Company, or (B) if there is no such method, as if such benefit accrued not more rapidly than at the slowest accrual rate permitted under Section 411(b)(1)(C) of the Code.

(b) The Accrued Benefit of any Employee shall be further determined as follows:

(1) The Accrued Benefit shall be calculated to include all amounts attributable to both Company and Employee contributions, but shall exclude amounts attributable to voluntary deductible employee contributions, if any.

(2) The present values of an Accrued Benefit of an Employee as of the Determination Date shall be increased by the distributions made with respect to the Employee under the Plan and any plan aggregated with the Plan under Section 416(g)(2) of the Code during the one-year period ending on the Determination Date. The preceding sentence shall also apply to distributions under a terminated plan which, had it not been terminated, would have been aggregated with the Plan under Section 416(g)(2)(A)(i) of the Code. In the case of a distribution made for a reason other

than severance from employment, death, or Disability, this provision shall be applied by substituting "five-year period" for "one-year period".

(3) Rollover and direct plan-to-plan transfer shall be taken into account as follows:

(A) If the transfer is initiated by the Employee and made from a plan maintained by one employer to a plan maintained by another unrelated employer, the transferring plan shall continue to count the amount transferred; the receiving plan shall not count the amount transferred if accepted after December 31, 1983, but shall count such amount if accepted prior to December 31, 1983.

(B) If the transfer is not initiated by the Employee or is made between plans maintained by related employers, the transferring plan shall no longer count the amount transferred; the receiving plan shall count the amount transferred.

(4) The Accrued Benefit of an Employee who is a Non-Key Employee with respect to any plan for the plan year but who was a Key Employee with respect to such plan for any prior plan year shall not be taken into account.

(5) The Accrued Benefit of any individual who has performed no services for the employer maintaining the plan at any time during the one-year period ending on the Determination Date shall not be taken into account.

11.4 Determination of Top-Heavy Status. This Plan shall be considered to be a top-heavy plan for any Plan Year if, as of the Determination Date, the value of the Accrued Benefits of Key Employees exceeds 60% of the value of the Accrued Benefits of all eligible Employees under the Plan. Notwithstanding the foregoing, if the Participating Company or any Affiliated Company maintains any other qualified plan, the determination of whether this Plan is top-heavy shall be made after aggregating all other plans of the Participating Company and any Affiliated Company in the Required Aggregation Group and, if desired by the Participating Company as a means of avoiding top-heavy status, after aggregating any other plan of the Participating Company and any Affiliated Company in the Permissive Aggregation Group. If the Required Aggregation Group is top-heavy, then each plan contained in such group shall be deemed to be top-heavy, notwithstanding that any particular plan in such group would not otherwise be deemed to be top-heavy. Conversely, if the Permissive Aggregation Group is not top-heavy, then no plan contained in such group shall be deemed to be top-heavy, notwithstanding that any particular plan in such group would otherwise be deemed to be top-heavy. In no event shall a plan included in a top-heavy Permissive Aggregation Group be deemed a top-heavy plan unless such plan is also included in a top-heavy Required Aggregation Group.

11.5 Minimum Contribution.

(a) For any year in which the Plan is top-heavy, each Non-Key Employee who has met the age and service requirement for participation, if any, in the Plan, shall be entitled to a minimum contribution equal to a percentage of such Non-Key Employee's Compensation as follows:

(1) If the Non-Key Employee is not covered by a

defined benefit plan maintained by the Participating Company or any Affiliated Company, then the minimum contribution under this Plan shall be 3% of such Non-Key Employee's Compensation.

(2) If the Non-Key Employee is covered by a defined benefit plan maintained by the Participating Company or any Affiliated Company, then the minimum contribution under this Plan shall be 5% of such Non-Key Employee's Compensation.

(b) Notwithstanding the foregoing, the minimum contribution otherwise allocable to a Non-Key Employee under this Plan shall be reduced in the following circumstances:

(1) The percentage minimum contribution required under this Plan shall in no event exceed the percentage contribution made for the Key Employee for whom such percentage is the highest for the Plan Year after taking into account contributions under other defined contribution plans in this Plan's Required Aggregation Group; provided, however, that this Section 11.5(b)(1) shall not apply if this Plan is included in a Required Aggregation Group and this Plan enables a defined benefit plan in such Required Aggregation Group to meet the requirements of Section 401(a)(4) or 410 of the Code.

(2) No minimum contribution shall be required (or the minimum contribution shall be reduced, as the case may be) for a Non-Key Employee under this Plan for any Plan Year if the Participating Company or any Affiliated Company maintains another qualified plan under which a minimum benefit or contribution is being accrued or made on account of such Plan Year, in whole or in part, on behalf of the Non-Key Employee, in accordance with Section 416(c) of the Code.

(c) For purposes of satisfying the minimum contribution requirements contained in this Section 11.5, there shall be disregarded (1) any Company contributions attributable to a salary reduction or similar arrangement, and (2) any Participating Company or Affiliated Company contributions to or any benefits under Chapter 21 of the Code (relating to the Federal Insurance Contributions Act), Title II of the Social Security Act, or any other federal or state law.

(d) For purposes of this Section 11.5, minimum contributions shall be required to be made on behalf of only those Non-Key Employees, as described in Section 11.5(a), who have not terminated employment as of the last day of the Plan Year. If a Non-Key Employee is otherwise entitled to receive a minimum contribution pursuant to this Section 11.5(d), the fact that such Non-Key Employee (1) failed to complete 1,000 Hours of Service (or such lesser requirement, if any, contained in the Plan), (2) failed to make any mandatory contributions (or any elective contributions under a Section 401(k) plan) under the Plan, if any are so required, or (3) was compensated at less than a stated amount shall not preclude him from receiving such minimum contribution.

ARTICLE XII

RIGHTS OF ALTERNATE PAYEES

12.1 General. Except as otherwise provided in this Article, an Alternate Payee shall have no rights to a Participant's benefit and shall have no rights under this Plan other than those rights specifically granted to the Alternate Payee pursuant to a Qualified Domestic Relations Order. Notwithstanding the foregoing, an Alternate Payee shall have the right to appeal the denial of a claim for any benefits awarded to the Alternate Payee pursuant to a Qualified Domestic Relations Order, as provided in Section 14.4. Any interest of an Alternate Payee in the Accounts of a Participant, other than an interest payable solely upon the Participant's death pursuant to a Qualified Domestic Relations Order which provides that the Alternate Payee shall be treated as the Participant's surviving Spouse, shall be separately accounted for by the Trustee in the name and for the benefit of the Alternate Payee.

12.2 Distribution.

(a) Notwithstanding anything in this Plan to the contrary, a Qualified Domestic Relations Order may provide that any benefits of a Participant payable to an Alternate Payee shall be distributed immediately or at any other time specified in the order. If the order does not specify the time at which benefits shall be payable to the Alternate Payee, the benefits shall be distributed to the Alternate Payee immediately.

(b) If a Qualified Domestic Relations Order does not provide the form of distribution of benefits payable to an Alternate Payee, the Alternate Payee shall have the right to elect distribution in any form provided under Article V, except that benefits to be paid in installments may not be paid over a period exceeding the life expectancy of the Alternate Payee, determined as of the date of the first distribution.

(c) If the Qualified Domestic Relations Order does not specify the Investment Media from which amounts shall be paid to an Alternate Payee, such amounts shall be distributed from the Investment Media in which such Accounts are invested on a pro rata basis.

12.3 Withdrawals. Unless a Qualified Domestic Relations Order provides to the contrary, an Alternate Payee shall not be permitted to make any withdrawals under Article IX.

12.4 Death Benefits. An Alternate Payee shall have the right to designate a beneficiary, in the same manner as provided in Section 5.10 with respect to a Participant (except that no spousal consent shall be required), who shall receive benefits payable to the Alternate Payee which have not been distributed at the time of the Alternate Payee's death. If the Alternate Payee does not designate a beneficiary, or if the beneficiary predeceases the Alternate Payee, benefits payable to the Alternate Payee which have not been distributed shall be paid to the Alternate Payee's estate.

12.5 Investment Direction. Unless a Qualified Domestic Relations Order provides to the contrary, an Alternate Payee shall have the right to direct the investment of any portion of a Participant's Accounts payable to the Alternate Payee under such order in the same manner as provided in Article XV with respect to a

Participant, which amounts shall be separately accounted for by the Trustee in the Alternate Payee's name.

ARTICLE XIII

IMPLEMENTATION OF SETTLEMENT AGREEMENT

13.1 Definitions. For purposes of this Article XIII, the following terms shall have the meanings prescribed herein:

“Plaintiff” means any individual on whose behalf the Company is required to make a payment in accordance with Paragraph 10 of the Settlement Agreement, and for whom the Company elects to make such payment in the form of a contribution to the Plan. Any Plaintiff who is not otherwise a Participant on the date on which a Plan Account is established for him pursuant to the Settlement Agreement shall, on and after such date, be deemed to be a Participant in accordance with the terms of the Plan.

“Settlement Agreement” means the Class Action Settlement Agreement in the matter of Paul Handy et al. v. Perdue Farms, Inc., et al., civil action No. WMN 03-CV-2281, United States District Court for District of Maryland, Northern Division, as executed July 29, 2005.

“Settlement Fund” means, of the aggregate dollar amount that the Company is required to pay the Plaintiffs, either directly or indirectly, pursuant to Paragraph 10 of the Settlement Agreement, the amount that the Company elects to contribute to the Plan.

13.2 Plan Contributions. The Company shall contribute to the Plan an amount equal to the Settlement Fund.

13.3 Allocation of Plan Contributions. The contribution described in Section 13.2 shall be allocated among the Company Basic Accounts of all Plaintiffs in accordance with the Plan of Allocation described in Paragraph 10 of the Settlement Agreement. For any Plaintiff who, immediately prior to such allocation, does not have a Company Basic Account, the Company shall cause such an Account to be established in his name.

13.4 Vesting. Each Plaintiff shall be fully and immediately vested in the amount allocated to his Account pursuant to this Article XIII.

13.5 Applicability of Plan Provisions Generally. A Plaintiff's rights with respect to the amount allocated pursuant to this Article XIII shall be governed by the provisions of the Plan generally, including, without limitation, provisions with respect to investments, in-service withdrawals, loans, and the form and timing of distributions from the Plan.

ARTICLE XIV
ADMINISTRATION

14.1 Committee. If the Company designates one or more individuals as the Committee, the powers and duties of the Committee under the Plan shall be exercised by the Committee; otherwise all such powers and duties shall be exercised by the Company. The Committee shall be the named fiduciary which shall control and manage the operation of the Plan and shall administer the Plan. The Committee members may, but need not, be Employees, and they shall serve at the pleasure of the Company. They shall be entitled to reimbursement of expenses, but those members of the Committee who are also Employees of a Participating Company shall receive no compensation for their service on the Committee. Any reimbursement of expenses of the Committee members shall be paid directly by the Company. The Committee shall be responsible for the general administration of the Plan under the policy guidance of the Company. As of the Effective Date, the Perdue Farms Inc. Investment Committee serves as the Committee, in accordance with its charter (which was effective April 26, 2013, as amended from time to time) (the "Charter").

14.2 Duties and Powers of Committee. The duties and powers of the Committee are set forth in the Charter. The Committee shall have sole and absolute power and discretion in carrying out its responsibilities, including its authority and responsibility to interpret or construe the provisions of the Plan and the Trust Agreement, and to resolve all questions that arise under the Plan or the Trust Agreement, including (but not limited to) questions of eligibility and of the status, rights and claims of Participants and beneficiaries. Any decisions and determinations made by the Committee pursuant to its duties and powers described in the Plan shall be conclusive and binding upon all parties. The expenses incurred by the Committee in connection with the operation of the Plan, including, but not limited to, the expenses incurred by reason of the engagement of professional assistants and consultants, shall be expenses of the Plan and shall be payable from the Fund at the direction of the Committee. The Participating Companies shall have the option, but not the obligation, to pay any such expenses, in whole or in part, and, by so doing, to relieve the Fund from the obligation of bearing such expenses. Payment of any such expenses by a Participating Company on one occasion shall not bind that Participating Company to pay any similar expenses on any subsequent occasion.

14.3 Functioning of Committee. The Committee and those persons or entities to whom the Committee has delegated responsibilities shall keep accurate records and minutes of meetings, interpretations, and decisions. The Committee shall act in accordance with its Charter as set forth therein.

14.4 Claims Procedures.

(a) Any person claiming a benefit under the Plan (a "Claimant") shall apply for such benefit by filing a claim with the Committee in writing on the form or forms prescribed by the Committee. If no form or forms have been prescribed, a claim for benefits shall be made in writing to the Committee setting forth the basis for the claim. The Claimant shall furnish the Committee with such documents,

evidence, data, or information in support of such claims as the Committee considers necessary or desirable. The Committee shall respond in writing.

(b) If the Committee denies, in whole or in part, a claim for benefits by a Participant or his beneficiary, the Committee shall furnish notice of the denial to the claimant in writing, setting forth:

- (1) the specific reasons for the denial;
- (2) specific reference to the pertinent Plan provisions on which the denial is based;
- (3) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary; and
- (4) an explanation of the Plan's claims review procedure, the time limits applicable to such procedures, and that the claimant has a right, to bring action under Section 502(a) of ERISA following an adverse benefit determination on review.

Such notice shall be forwarded to the claimant within 90 days of the Committee's receipt of the claim, provided, however, that in special circumstances the Committee may extend the response period for up to an additional 90 days, in which event it shall notify the claimant in writing of the extension, and shall specify the reason or reasons for the extension.

(c) Any Claimant whose claim is denied (or such Claimant's authorized representative) may, within 60 days after the Claimant's receipt of notice of the denial, request a review of the denial by notice given, in writing, to the Committee. Upon such a request for review, the claim shall be reviewed by the Committee (or its designated representative) which may, but shall not be required to, grant the Claimant a hearing.

(d) In connection with the review, the Claimant may have representation. Upon request and free of charge, the Claimant shall be provided reasonable access to, and copies of, all relevant documents, records and information. The Claimant may also submit comments, documents, records and other relevant information in writing to the Committee.

(e) (1) The decision on review normally shall be made within 60 days of the Committee's receipt of the request for review. If an extension of time is required due to special circumstances, the Claimant shall be notified, in writing, by the Committee, and the time limit for the decision on review shall be extended to 120 days. Any extension notice shall indicate the special circumstances requiring the extension and the date on which the Committee expects to render a decision on appeal. The written decision on review shall be given to the Claimant within the 60-day (or, if applicable, the 120-day) time limit discussed above.

(2) Notwithstanding the foregoing Paragraph (1), if the Committee holds regularly scheduled meetings at least quarterly, the Committee shall make its decision on review no later than the date of the Committee meeting which

immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of a request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the third meeting following the Plan's receipt of a request for review. If such an extension is required, written notice of the extension shall be furnished by the Committee to the Claimant prior to the extension and shall indicate the special circumstances requiring the extension and the date on which the Committee expects to render a decision on appeal. The Committee shall notify the Claimant in writing of the benefit determination as soon as possible, but no later than 5 days after the benefit determination is made.

(3) The decision on review shall be in writing, and if it is adverse shall state, in a manner calculated to be understood by the Claimant:

(A) The specific reason or reasons for the decision, with specific references to the relevant Plan provisions on which the decision is based;

(B) That the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits; and

(C) That the Claimant has a right to bring an action under Section 502(a) of ERISA.

(4) All decisions on review shall be final and binding with respect to all concerned parties. The claims procedure set forth in this Section 14.4 shall in all events be interpreted to comply with the provisions of Section 503 of ERISA and applicable regulations issued thereunder.

(f) No action claiming benefits may be brought under Section 502(a) of ERISA more than three years after the occurrence of the facts or circumstances that give rise to or form the basis for the action.

14.5 Indemnification. Each member of the Committee, and any other person who is an Employee or director of a Participating Company or an Affiliated Company, shall be indemnified and held harmless by the Company against and with respect to all damages, losses, obligations, liabilities, liens, deficiencies, costs and expenses, including without limitation, reasonable attorney's fees and other costs incident to any suit, action, investigation, claim or proceedings to which he may be a party by reason of his performance of administrative functions and duties under the Plan, except in relation to matters as to which he shall be held liable for an act of willful misconduct in the performance of his duties. The foregoing right to indemnification shall be in addition to such other rights as the Committee member or other person may enjoy as a matter of law or by reason of insurance coverage of any kind or under the terms of the Committee's Charter. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the Committee member or other person may be entitled pursuant to the by-laws of the Participating Company.

ARTICLE XV

THE FUND

15.1 Designation of Trustee. The Company, by appropriate resolution of its Board of Directors, if any, shall name and designate a Trustee and shall enter into a Trust Agreement. The Company shall have the power, by appropriate resolution of its Board of Directors, to amend the Trust Agreement, remove the Trustee, and designate a successor Trustee, as provided in the Trust Agreement. All of the assets of the Plan shall be held by the Trustee for use in accordance with the Plan.

15.2 Exclusive Benefit. Prior to the satisfaction of all liabilities under the Plan in the event of termination of the Plan, no part of the corpus or income of the Fund shall be used for or diverted to purposes other than for the exclusive benefit of Participants and their beneficiaries except as expressly provided in this Plan and in the Trust Agreement.

15.3 No Interest in Fund. No person shall have any interest in or right to any part of the assets or income of the Fund, except to the extent expressly provided in this Plan and in the Trust Agreement.

15.4 Trustee. The Trustee shall be the named fiduciary with respect to management and control of Plan assets held by it and, except as provided in Section 15.5, shall have exclusive and sole responsibility for the custody and investment thereof in accordance with the Trust Agreement.

15.5 Investments.

(a) Except as provided in Subsection (e) of this Section, the Trustee shall invest the contributions paid to it under the Plan and income thereon in such Investment Media as each Participant may select in accordance with this Section. Such investments acquired in the manner prescribed by the Plan shall be held by or for the Trustee.

(b) Except as provided in Subsection (e) of this Section, a Participant shall select by Written Election one or more of the Investment Media in which his Accounts shall be invested, and the percentage thereof that shall be invested in each Investment Medium selected. In the event a Participant fails to make an election pursuant to this Section, amounts allocated to his Account shall be invested as determined by the Committee. A Participant may amend such selection, effective as of such dates determined by the Committee, by Written Election. Such amendments will be subject to the other requirements of this Section.

(c) A Participant may transfer by Written Election, effective as of such dates determined by the Committee, such portion of the value of his interest in any Investment Medium to another Investment Medium, as may be permitted by the Committee.

(d) The amounts contributed by all Participants to each Investment Medium shall be commingled for investment purposes.

(e) The Trustee may hold assets of the Fund and make distributions therefrom in the form of cash without liability for interest, if for administrative purposes it becomes necessary or practical to do so.

ARTICLE XVI

AMENDMENT OR TERMINATION OF THE PLAN

16.1 Power of Amendment and Termination.

(a) It is the intention of each Participating Company that this Plan will be permanent. However, each Participating Company reserves the right to terminate its participation in this Plan at any time by or pursuant to action of its board of directors or other governing body. Furthermore, the Company reserves the power to amend or terminate the Plan at any time by or pursuant to action of the Board of Directors. As of the Effective Date, the Board of Directors has delegated to the Committee under the terms of its Charter the authority to amend the Plan if such amendments do not have a material financial impact on the Company.

(b) Each amendment to the Plan shall be binding on each Participating Company if such Participating Company, by or pursuant to action by its board of directors or other governing body, (1) consents to such amendment at any time; or (2) fails to object thereto within thirty days after receiving notice thereof.

(c) Any amendment or termination of the Plan shall become effective as of the date designated by the Board of Directors or its delegate. Except as expressly provided elsewhere in the Plan, prior to the satisfaction of all liabilities with respect to the benefits provided under this Plan, no amendment or termination shall cause any part of the monies contributed hereunder to revert to the Participating Companies or to be diverted to any purpose other than for the exclusive benefit of Participants and their beneficiaries. Upon termination or partial termination of the Plan, or upon complete discontinuance of contributions, the rights of all affected persons to benefits accrued to the date of such termination shall be nonforfeitable. Upon termination of the Plan without establishment or maintenance of another defined contribution plan (other than an employee stock ownership plan as defined in Section 4975(e)(7) or 409(a) of the Code, a simplified employee pension plan as defined in Section 408(k) of the Code, a SIMPLE IRA as defined in Section 408(p) of the Code, a plan or contract that satisfies the requirements of Section 403(b) of the Code, or a plan that is described in Section 457(b) or (f) of the Code), Accounts shall be distributed in accordance with applicable law.

(d) No amendment to the Plan shall have the effect of reducing, eliminating, or subjecting to employer discretion the benefit accrued by any Participant through the later of (1) the effective date of the amendment, or (2) the adoption date of the amendment, except to the extent permitted by regulations.

16.2 Merger. The Plan shall not be merged with or consolidated with, nor shall its assets be transferred to, any other qualified retirement plan unless each Participant would receive a benefit after such merger, consolidation, or transfer (assuming the Plan then terminated) which is of actuarial value equal to or greater than the benefit he would have received from his Account if the Plan had been terminated on the day before such merger, consolidation, or transfer.

ARTICLE XVII

GENERAL PROVISIONS

17.1 Adoption and Withdrawal.

(a) Any Affiliated Company may adopt this Plan if the approval of the Company and such Affiliated Company is obtained, and if such documents as are necessary to make such Affiliated Company a party to the Plan and Trust as a Participating Company are executed. An Affiliated Company which adopts the Plan shall be a Participating Company with respect to its Employees for purposes of the Plan. In the event that the Plan is adopted by one (1) or more Affiliated Companies, all matters pertaining to the administration of the Plan shall be governed by the Company, and all directions to the Trustee shall apply to the entire Fund, without distinction as to the portion thereof contributed by any Participating Company.

(b) Any Participating Company may at any time withdraw from the Plan upon giving the Trustee at least ninety (90) days' notice in writing of its intention to withdraw, or such other notice as may be required by the applicable provisions of the Trust Agreement. Upon the written request of a withdrawing Participating Company, but subject to the requirements of Sections 414(1) and 411(d)(6) of the Code, the Trustee may segregate a share of the assets of the Fund, the value of which shall be equal to the total amounts credited to the Accounts of Participants of the withdrawing Participating Company, adjusted to reflect income, losses, appreciation, and depreciation, and charges and expenses related thereto, to the date such assets are segregated, and such assets may be transferred to a trust with respect to any tax-qualified plan established for the benefit of the employees of such Participating Company that meets the requirements of Section 401(a) of the Code; provided, however, that neither the segregation nor the transfer of such assets upon the withdrawal of a Participating Company shall operate to permit any part of the assets to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and beneficiaries.

17.2. No Employment Rights. Neither the action of the Company in establishing the Plan, nor of any Participating Company in adopting the Plan, nor any provisions of the Plan, nor any action taken by the Company, any Participating Company or the Committee shall be construed as giving to any Employee the right to be retained in the employ of the Company or any Participating Company, or any right to payment except to the extent of the benefits provided in the Plan to be paid from the Fund.

17.3 Governing Law; Interpretation.

(a) Except to the extent superseded by ERISA, all questions pertaining to the validity, construction, and operation of the Plan shall be determined in accordance with the laws of the state in which the principal place of business of the Company is located.

(b) It is the intention of the Company, and of all Participating Companies, that the provisions of the Plan and the Trust shall be interpreted and applied in a uniform manner and shall in all other respects be operated as a tax-qualified plan and trust which shall meet the requirements of Sections 401(a) and 501(a) of the Code and the requirements of ERISA.

17.4 Severability of Provisions. If any provision of this Plan is determined to be void by any court of competent jurisdiction, the Plan shall continue to operate and, for the purposes of the jurisdiction of that court only, shall be deemed not to include the provisions determined to be void.

17.5 No Interest in Fund. No person shall have any interest in, or right to, any part of the principal or income of the Fund, except as and to the extent expressly provided in this Plan and in the Trust Agreement.

17.6 Spendthrift Clause. No benefit payable at any time under this Plan and no interest or expectancy herein shall be anticipated, assigned, or alienated by any Participant or beneficiary, or subject to attachment, garnishment, levy, execution, or other legal or equitable process, except for (a) a Federal tax levy made pursuant to Section 6331 of the Code and (b) any benefit payable pursuant to a Qualified Domestic Relations Order and (c) an offset of a Participant's benefits as described in Section 206(d)(4) of ERISA. Any attempt to alienate or assign a benefit hereunder, whether currently or hereafter payable, shall be void.

17.7 Incapacity. If the Committee deems any Participant or beneficiary who is entitled to receive payments hereunder incapable of receiving or disbursing the same by reason of age, illness, infirmity, or incapacity of any kind, the Committee may direct the Trustee to apply such payments directly for the comfort, support, and maintenance of such Participant or beneficiary, or to pay the same to any responsible person caring for the Participant or beneficiary who is determined by the Committee to be qualified to receive and disburse such payments for the Participant's or beneficiary's benefit; and the receipt of such person shall be a complete acquittance for the payment of the benefit. Payments pursuant to this Section 17.7 shall be complete discharge to the extent thereof of any and all liability of the Participating Companies, the Committee, the Trustee, and the Fund.

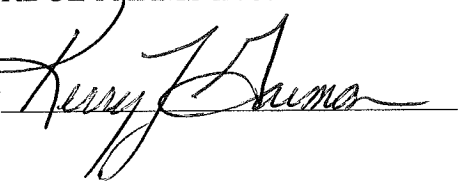
17.8 Withholding. The Committee and the Trustee shall have the right to withhold any and all state, local, and Federal taxes which may be withheld in accordance with applicable law.

17.9 Missing Persons. When benefits are payable to any Participant or his beneficiary, and such Participant or beneficiary cannot be located, the Participant's (or beneficiary's) benefits shall continue to be held under the Plan, and the Committee shall use reasonable, diligent efforts to locate the Participant or his beneficiary. In the event that after a reasonable period of time from the date such benefits are due, all or any portion of the distribution payable to the Participant or his beneficiary hereunder shall remain unpaid despite the Committee's reasonable and diligent efforts, the amount so distributable shall be treated as having been forfeited and shall be used to reduce the cost of the Plan or, in the alternative, the Committee may distribute the funds using any method that has been approved by the Internal Revenue Service or the Department of Labor for the distribution of accounts of missing plan participants. Notwithstanding the foregoing, in the event that a Participant or beneficiary is subsequently located after his benefit has been forfeited (and prior to the termination of the Plan), such benefit shall be restored and shall be paid to the Participant or beneficiary in accordance with the terms of the Plan.

Executed this 24th day of January, 2014.

PERDUE FARMS INC.

By

A handwritten signature in cursive script, appearing to read "Kerry J. Dunn", is written over a horizontal line.

APPENDIX A

Notwithstanding any provision of this Plan to the contrary, with respect to any period in which an Eligible Employee is employed by a Participating Company or Affiliated Company designated in any Part of this Appendix during a time period designated in this Appendix, the Plan shall be deemed to be modified as set forth below (or as set forth in Appendix B, as applicable) with respect to such Eligible Employee.

A-1: SPECIAL PROVISIONS APPLICABLE TO ELIGIBLE EMPLOYEES AT THE COMPANY'S PETERSBURG, WV FACILITIES

(1) Recognition of Pre-acquisition Service. The service of an Employee described in this Part A-1 with Advantage Foods, LLC prior to December 4, 1998 shall be recognized for purposes of Article VI and Section 2.2, but only if such Employee was an employee of Advantage Foods, LLC as of December 3, 1998 and became an Employee on the following day. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to January 1, 1999.

(2) Vesting Provisions. For an Eligible Employee described in this Part A-1, Subsection 6.1(b)(1) and Subsection 6.5(c) are modified as follows, but solely with respect to his Company Match Account:

[Subsection 6.1(b)(1):]

A Participant shall have a nonforfeitable interest in his Company Match Account determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 3 years	0 percent
3 years or more	100 percent

[Subsection 6.5(c):]

(c) If a Participant who is deemed to have received a distribution described in Paragraph (a)(1) of this Section, whereby his Account has been forfeited, again becomes a Covered Employee prior to incurring five consecutive one-year Breaks in Service, he shall be deemed to have repaid the amount of the distribution and the amount so forfeited shall be restored to his Company Match Account as soon as practicable after the date he again becomes a Covered Employee. Amounts restored under this Subsection shall be charged against the following amounts in the

following order of priority: (1) forfeitures for the Plan Year, (2) income or gains or losses to the Plan, and (3) Company contributions for the Plan Year. If the foregoing amounts are insufficient, the Participating Company by whom such Participant is reemployed shall make any additional contribution necessary to accomplish the restoration.

A-2: SPECIAL PROVISIONS APPLICABLE TO ELIGIBLE EMPLOYEES AT THE COMPANY'S MONTEREY, TN OR BRENTWOOD, TN FACILITIES

(1) Recognition of Pre-acquisition Service. The service of an Employee described in this Part A-2 with Gol-Pak Holdings, Inc. or Fast Food Merchandisers, Inc. prior to October 19, 1998 shall be recognized for purposes of Article VI and Section 2.2, but only if such Employee was an employee of Gol-Pak Holdings, Inc. or Fast Food Merchandisers, Inc. as of October 18, 1998 and became an Employee on the following day. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to October 19, 1998.

(2) Vesting Provisions. For an Eligible Employee described in this Part A-2, Subsection 6.1(b)(1) and Subsection 6.5(c) are modified as follows, but solely with respect to his Company Match Account:

[Subsection 6.1(b)(1):]

A Participant shall have a nonforfeitable interest in his Company Match Account determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 3 years	0 percent
3 years or more	100 percent

[Subsection 6.5(c):]

(c) If a Participant who is deemed to have received a distribution described in Paragraph (a)(1) of this Section, whereby his Account has been forfeited, again becomes a Covered Employee prior to incurring five consecutive one-year Breaks in Service, he shall be deemed to have repaid the amount of the distribution and the amount so forfeited shall be restored to his Company Match Account as soon as practicable after the date he again becomes a Covered Employee. Amounts restored under this Subsection shall be charged against the following amounts in the

following order of priority: (1) forfeitures for the Plan Year, (2) income or gains or losses to the Plan, and (3) Company contributions for the Plan Year. If the foregoing amounts are insufficient, the Participating Company by whom such Participant is reemployed shall make any additional contribution necessary to accomplish the restoration.

A-3: SPECIAL PROVISIONS APPLICABLE TO ELIGIBLE EMPLOYEES OF DELUCA, INC.

(1) Recognition of Pre-acquisition Service. The service of an Employee described in this Part A-3 with DeLuca, Inc. prior to September 3, 1998 shall be recognized for purposes of Section 2.2, but only if such Employee was an employee of DeLuca, Inc. as of September 2, 1998 and became an Employee on the following day. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to October 1, 1998.

A-4: SPECIAL PROVISIONS APPLICABLE TO FORMER EMPLOYEES OF SOUTHERN STATES COOPERATIVE INCORPORATED

(1) Recognition of Certain Prior Service. The service of an Employee described in this Part A-4 with Southern States Cooperative Incorporated prior to September 23, 2002 shall be recognized for purposes of Section 2.2, but only if such Employee was employed by Southern States Cooperative Incorporated immediately prior to becoming an Employee. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to October 1, 2002.

A-5: SPECIAL PROVISIONS APPLICABLE TO EMPLOYEES OF W.O. WHITELY & SON, INC.

(1) Recognition of Certain Prior Service. The service of an Employee described in this Part A-5 with W.O. Whitely and Son, Inc. prior to August 12, 2002 shall be recognized for purposes of Section 2.2, but only if such Employee was employed by W.O. Whitely and Son, Inc. as of August 11, 2002. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to October 1, 2002.

A-6: SPECIAL PROVISIONS APPLICABLE TO FORMER EMPLOYEES OF MANAURE MANAGEMENT INCORPORATED

(1) Recognition of Certain Prior Service. The service of an Employee described in this Part A-6 with Manaure Management Incorporated shall be recognized for purposes of Section 2.2, but only if such Employee was employed by Manaure

Management Incorporated as of the day immediately preceding the day he first became an Employee. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to October 1, 2002.

A-7: SPECIAL PROVISIONS APPLICABLE TO ELIGIBLE FORMER EMPLOYEES OF PACMA

(1) Recognition of Pre-acquisition Service. The service of an Employee described in this Part A-7 with PACMA prior to July 30, 2004 shall be recognized for purposes of Section 2.2 and Section 6.2, but only if such Employee was an employee of PACMA as of July 29, 2004 and became an Employee on the following day. Notwithstanding the foregoing, no such Eligible Employee shall become a Covered Employee prior to July 30, 2004.

A-8: SPECIAL PROVISIONS APPLICABLE TO EMPLOYEES IN THE COLEMAN NATURAL FOODS, LLC 401(k) PLAN PRIOR TO JANUARY 1, 2013

Prior to January 1, 2013, Eligible Employees of Coleman Natural Foods, LLC and certain Affiliated Companies (collectively, "Coleman") participated in the Coleman Natural Foods, LLC 401(k) Plan (the "CNF Plan"). Effective as of January 1, 2013, the CNF Plan was merged into the Plan. Notwithstanding any provision of the Plan to the contrary, the Plan shall be deemed to be modified, as set forth in this Appendix Part A-8, with respect to such Coleman Employees.

(1) Recognition of Prior Service. The service of an Employee described in this Appendix Part A-8 which was recognized under the CNF Plan prior to January 1, 2013 shall be recognized for purposes of the Plan. Notwithstanding the foregoing, no such Employee shall become a Covered Employee prior to January 1, 2013.

(2) Eligibility to Participate. Notwithstanding Sections 2.2, 2.3 and 2.4, and except as otherwise provided in Appendix B, the following rules shall apply for the purpose of determining eligibility to participate in the Plan.

(a) For purposes of Section 2.2:

(1) Each Eligible Employee as of January 1, 2013 who was eligible to make Salary Reduction Contributions immediately prior to January 1, 2013 under the CNF Plan shall continue to be an Eligible Employee as of January 1, 2013 for purposes of making Salary Reduction Contributions and Voluntary Contributions.

(2) Each Covered Employee who was hired by Coleman prior to January 1, 2013 but who was not eligible to make Salary Reduction Contributions under the CNF Plan, and who has attained Age 18, shall become an Eligible Employee for purposes of making Salary Reduction Contributions and Voluntary Contributions upon the later of:

(A) January 1, 2013; or

(B) the first Payroll Period beginning after the date the Covered Employee has completed 30 days of employment with the Company or an Affiliated Company, if he is then a Covered Employee.

(b) For purposes of Section 2.3 (a) and (b):

(i) Each Covered Employee as of January 1, 2013 who would have been eligible to share in Safe Harbor Matching Contributions immediately prior to January 1, 2013 under the CNF Plan (assuming he was making Salary Reduction Contributions at that time) shall continue to be a Full Participant as of January 1, 2013.

(ii) Each Covered Employee who was hired by Coleman prior to January 1, 2013 but who was not eligible to share in Safe Harbor Matching Contributions immediately prior to January 1, 2013 under the CNF Plan (assuming he was making Salary Reduction Contributions at that time), and who has attained Age 18, shall become a Full Participant upon the later of:

(A) January 1, 2013; or

(B) the first day of the month coincident with or immediately following the date the Covered Employee has completed 90 days of employment with the Company or an Affiliated Company, if he is then a Covered Employee.

(3) Distributions. Notwithstanding Section 5.8, a Participant who has a Severance from Employment, and who is entitled to defer the commencement of his benefit, may defer the distribution of that portion of his Account attributable to pre-2013 contributions (adjusted for investment results) to any later date that occurs before his Required Beginning Date. This right constitutes a "protected benefit."

(4) Withdrawals. Section 9.2(a) shall also be deemed to include that portion of a Participant's Rollover Account (including after-tax rollovers) attributable to pre-2013 contributions (adjusted for investment results). The right of the Participant to withdraw this amount at any time without penalty constitutes a "protected benefit."

A-9: SPECIAL PROVISIONS APPLICABLE TO EMPLOYEES IN THE DRAPER VALLEY HOLDINGS, LLC NON-UNION RETIREMENT PLAN PRIOR TO JANUARY 1, 2013

Prior to January 1, 2013, Eligible Employees of Draper Valley Holdings, LLC ("Draper Valley") participated in the Draper Valley Holdings, LLC Non-Union Retirement Plan ("Draper Valley Non-Union Plan"). Effective as of January 1, 2013, the Draper Valley Non-Union Plan was merged into the Plan. Notwithstanding any provision of the Plan to the contrary, the Plan shall be deemed to be modified, as set forth in this Appendix Part A-9, with respect to former participants in the Draper Valley Non-Union Plan.

(1) Recognition of Prior Service. The service of an Employee described in this Appendix Part A-9 which was recognized under the Draper Valley Non-Union Plan

prior to January 1, 2013 shall be recognized for purposes of the Plan. Notwithstanding the foregoing, no such Employee shall become a Covered Employee prior to January 1, 2013.

(2) Eligibility to Participate. Notwithstanding Sections 2.2, 2.3 and 2.4, the following rules shall apply for the purpose of determining eligibility to participate in the Plan.

(a) For purposes of Section 2.2:

(1) Each Eligible Employee as of January 1, 2013 who was eligible to make Salary Reduction Contributions immediately prior to January 1, 2013 under the Draper Valley Non-Union Plan shall continue to be an Eligible Employee as of January 1, 2013 for purposes of making Salary Reduction Contributions and Voluntary Contributions.

(2) Each Covered Employee who was hired by Draper Valley prior to January 1, 2013 but who was not eligible to make Salary Reduction Contributions under the Draper Valley Non-Union Plan, and who has attained Age 21, shall become an Eligible Employee for purposes of making Salary Reduction Contributions and Voluntary Contributions upon the later of:

(A) January 1, 2013; or

(B) the date the Covered Employee has completed 30 days of service with the Company or an Affiliated Company, if he is then a Covered Employee.

(b) For purposes of Section 2.3:

(1) Each Covered Employee as of January 1, 2013 who would have been eligible to share in Safe Harbor Matching Contributions immediately prior to January 1, 2013 under the Draper Valley Non-Union Plan (assuming he was making Salary Reduction Contributions at that time) shall continue to be a Full Participant as of January 1, 2013.

(2) Each Covered Employee who was hired by Draper Valley prior to January 1, 2013 but who was not eligible to share in Safe Harbor Matching Contributions immediately prior to January 1, 2013 under the Draper Valley Non-Union Plan (assuming he was making Salary Reduction Contributions at that time), and who has attained Age 21, shall become a Full Participant upon the later of:

(A) January 1, 2013; or

(B) the January 1st, April 1st, July 1st or October 1st coincident with or immediately following the date the Covered Employee has completed six months of Eligibility Service, if he is then a Covered Employee.

(3) Distributions. Notwithstanding Section 5.8, a Participant who has a Severance from Employment, and who is entitled to defer the commencement of his benefit, may defer the distribution of that portion of his Account attributable to pre-2013 contributions (adjusted for investment results) to any later date that occurs before his Required Beginning Date. This right constitutes a "protected benefit."

(4) Vesting. Effective January 1, 2013 each Participant who had a Nonelective Contribution Account under the Draper Valley Non-Union Plan shall be 100% vested in such Account.

A-10: SPECIAL PROVISIONS APPLICABLE TO EMPLOYEES IN THE DRAPER VALLEY HOLDINGS, LLC 401(k) PLAN FOR UFCW LOCAL NO. 44 MEMBERS PRIOR TO JANUARY 1, 2013

Prior to January 1, 2013, Eligible Employees of Draper Valley Holdings, LLC ("Draper Valley") participated in the Draper Valley Farms, Inc. 401(k) Plan for UFCW Local No. 44 [now Local No. 21] Members (the "Draper Valley Union Plan"). Effective as of January 1, 2013, the Draper Valley Union Plan was merged into the Plan. Notwithstanding any provision of the Plan to the contrary, the Plan shall be deemed to be modified, as set forth in this Appendix Part A-10, with respect to former participants in the Draper Valley Union Plan.

(1) Recognition of Prior Service. Except as otherwise provided in Appendix B-2(9)(e), the service of an Employee described in this Appendix Part A-10 which was recognized under the Draper Valley Union Plan prior to January 1, 2013 shall be recognized for purposes of the Plan. Notwithstanding the foregoing, no such Employee shall become a Covered Employee prior to January 1, 2013.

APPENDIX B

Notwithstanding any provision of the Plan to the contrary, with respect to any period in which a Covered Employee is a member of a collective bargaining unit identified in Part B-1 of this Appendix, the Plan shall be deemed to be modified as set forth in this Appendix with respect to such Covered Employee.

B-1: COLLECTIVE BARGAINING UNITS

The following collective bargaining units have successfully negotiated with one or more Participating Companies for participation in the Plan (as modified by the special provisions of this Appendix) by eligible members of such units:

- (1) United Food and Commercial Workers Union, Local No. 27, Milford, DE ("Milford").
- (2) International Union of Operating Engineers, Local No. 147, Chesapeake, VA ("Local 147").
- (3) International Longshoreman's Association, AFL-CIO, Local No. 1963, Chesapeake, VA ("Local 1963").
- (4) Effective October 1, 2008, United Food and Commercial Workers Union, Local No. 27, Accomac, VA ("Accomac").
- (5) Effective October 1, 2008, United Food and Commercial Workers Union, Local No. 27, Georgetown, MD ("Georgetown").
- (6) Effective October 1, 2008, United Food and Commercial Workers Union, Local No. 27, Salisbury, MD ("Salisbury").
- (7) Effective January 1, 2013, Golden State United Food and Commercial Workers Union, Local No. 8, Petaluma, CA ("Petaluma Local 8").
- (8) Effective January 1, 2013, United Food and Commercial Workers Union, Local No. 1776, Fredericksburg, PA ("BCNC Local 1776").
- (9) Effective January 1, 2013, Teamsters Union, Local No. 429, Wyomissing, PA ("BCNC Local 429").
- (10) Effective January 1, 2013, United Food and Commercial Workers Union, Local No. 21, Mount Vernon, WA ("Draper Valley Local 21 (Mt. Vernon)").

B-2: SPECIAL PROVISIONS APPLICABLE TO BARGAINING UNIT MEMBERS

(1) Notwithstanding Section 2.3, a Covered Employee who is a Bargaining Unit Member, but who is not employed by BCNC Local 429, shall not be deemed to be an Eligible Employee for purposes of Section 2.3 until he has become a Full Participant in accordance with Section 2.4.

(2) Subsection 2.4(b) shall read as follows with respect to any Bargaining Unit Member employed by Petaluma Local 8:

(b) (1) Each Covered Employee as of January 1, 2013 who was eligible to participate under the CNF Plan immediately prior to January 1, 2013 shall continue to be a Full Participant as of January 1, 2013;

(2) (A) Each Covered Employee who was hired by Coleman prior to January 1, 2013 but who was not eligible to share in Safe Harbor Matching Contributions assuming he was making Salary Reduction and/or Voluntary Contributions at the time) as of January 1, 2013, shall become a Full Participant upon the first day of the month coincident with or next following the date he meets the following requirements:

(i) he has attained Age 18; and

(ii) he has completed six months of Eligibility Service, if he is then a Covered Employee.

(B) Each Covered Employee who is hired on or after January 1, 2013 shall become a Full Participant upon the first day of the month coincident with or next following the date he meets the following requirements:

(i) he has attained Age 21; and

(ii) he has completed six months of Eligibility Service, if he is then a Covered Employee.

Subsection 2.4(b) shall read as follows with respect to any Bargaining Unit Member employed by BCNC Local 1776:

(b) (1) Each Covered Employee as of January 1, 2013 who was eligible to participate under the CNF Plan immediately prior to January 1, 2013 shall continue to be a Full Participant as of January 1, 2013;

(2) (A) Each Covered Employee who was hired by Coleman prior to January 1, 2013 but who was not an eligible participant under the CNF Plan as of January 1, 2013 shall become a Full Participant upon the later of:

(i) the date he attains age 21; or

(ii) the January 1st, April 1st, July 1st or October 1st coincident with or immediately following the date he completes a year of service under the elapsed time method set forth in Section 1.410(a)-7 of the Treasury regulations.

(B) Each Covered Employee who is hired on or after January 1, 2013, shall become a Full Participant upon the later of:

- (i) the date he attains age 21; or
- (ii) the January 1st, April 1st, July 1st, or October 1st coincident with or next following the date he has completed one Year of Eligibility Service; or

Subsection 2.4(b) shall read as follows with respect to any Bargaining Unit Member employed by Draper Valley Local 21 (Mt. Vernon):

(b) (1) Each Covered Employee as of January 1, 2013 who was eligible to participate under the Draper Valley Union Plan immediately prior to January 1, 2013 shall continue to be a Full Participant as of January 1, 2013;

(2) (A) Each other Covered Employee shall become a Full Participant upon the later of:

- (i) the date he attains age 21; or
- (ii) the January 1st, April 1st, July 1st or October 1st coincident with or immediately following the date he completes a year of service under the elapsed time method set forth in Section 1.410(a)-7 of the Treasury regulations.

(3) A Full Participant shall not be eligible to share in Discretionary Contributions under Section 2.7, with respect to any period in which he is a Bargaining Unit Member.

(4) As it applies to any Bargaining Unit Member, Subsection 3.1(a) shall read as follows:

(a) When an Eligible Employee makes an election under Section 2.5 to make Salary Reduction Contributions and/or Voluntary Contributions, he shall elect (1) the percentage by which his Compensation shall be reduced on account of such Salary Reduction Contributions and/or Voluntary Contributions, and (2) how such percentage is to be allocated between Salary Reduction Contributions and Voluntary Contributions. Such Salary Reduction Contributions and Voluntary Contributions shall be subject to the following limitations:

(1) for an Eligible Employee who is a Bargaining Unit Member employed by Milford, Local 147, Accomac, Georgetown, or Salisbury, the total amount of such Eligible Employee's Salary Reduction Matched Contributions shall be between one percent (1%) and four percent (4%) of such Eligible Employee's Compensation, rounded to the nearest whole percent; and

(2) for an Eligible Employee who is a Bargaining Unit Member employed by Local 1963, the total amount of such Eligible Employee's Salary Reduction Matched Contributions shall be between one percent (1%) and four percent

(4%) of such Eligible Employee's Compensation, rounded to the nearest whole percent; and

(3) for an Eligible Employee who is a Bargaining Unit Member employed by Petaluma Local 8 or BCNC Local 429, the total amount of such Eligible Employee's Salary Reduction Matched Contributions shall be between one percent (1%) and five percent (5%) of such Eligible Employee's Compensation, rounded to the nearest whole percent; and

(4) if the Eligible Employee is making Salary Reduction Matched Contributions, or a combination thereof, at the maximum rates described in Subsection (a)(1) hereof, he may also elect to have an additional percentage deducted from his Compensation as Salary Reduction Unmatched Contributions and/or Voluntary Unmatched Contributions, such that the total Salary Reduction Matching Contributions, Salary Reduction Unmatched Contributions, and Voluntary Unmatched Contributions, which are contributed by an Eligible Employee, shall not exceed twelve percent (12%) of his Compensation; provided, however, that a Participant shall be prohibited from making such additional Voluntary Unmatched Contributions in any Plan Year with respect to which he is a Highly Compensated Employee. Notwithstanding the foregoing, (i) for an Eligible Employee who is a Bargaining Unit Member employed by Local 1963, the total Salary Reduction Matched Contributions, Salary Reduction Unmatched Contributions, and Voluntary Unmatched Contributions, which are contributed by an Eligible Employee, shall not exceed twenty-five percent (25%) of his Compensation; (ii) for an Eligible Employee who is a Bargaining Unit Member employed by BCNC Local 429 or Draper Valley Local 21 (Mt. Vernon), the total Salary Reduction Matched Contributions, Salary Reduction Unmatched Contributions, and Voluntary Unmatched Contributions, which are contributed by an Eligible Employee, shall not exceed seventy-five percent (75%) of his Compensation; (iii) for an Eligible Employee who is a Bargaining Unit Member employed by Petaluma Local 8, the total Salary Reduction Matched Contributions, Salary Reduction Unmatched Contributions, and Voluntary Unmatched Contributions, which are contributed by an Eligible Employee, shall not exceed one hundred percent (100%) of his Compensation; and

(5) The Participating Company shall contribute an amount equal to such percentages of the Eligible Employee's Compensation to the Fund for credit to the Eligible Employee's 401(k) Account and/or Voluntary Unmatched Account, as the case may be.

(5) Subsection 3.1(c) shall only apply to those Bargaining Unit Members employed by Petaluma Local 8, BCNC Local 1776, BCNC Local 429 and Draper Valley Local 21 (Mt. Vernon).

(6) As it applies to any Bargaining Unit Member, Section 3.4 shall read as follows:

3.4 Matching Contribution.

(a) Subject to Section 3.8,

(i) A Participating Company shall contribute to the Fund for Eligible Employees who are Bargaining Unit members employed by Milford, Local 147, Accomac, Georgetown, or Salisbury or Local 1963, an amount equal to seventy-five percent (75%) of all such Eligible Employees' Salary Reduction Matched Contributions for each Payroll Period, offset by the amount, if any, of Applied Forfeitures during such Payroll Period.

(ii) A Participating Company shall contribute to the Fund for Eligible Employees who are Bargaining Unit members employed by Petaluma Local 8 or BCNC Local 429, an amount equal to one hundred (100%) of all such Eligible Employees' Salary Reduction Matched Contributions for each Payroll Period up to the first three percent of the Eligible Employee's Compensation, plus fifty percent (50%) of the next two percent (2%) of the Eligible Employee's Compensation, offset by the amount, if any, of Applied Forfeitures during such Payroll Period.

(b) The contributions under this Section for any Plan Year shall not cause the total contributions by the Participating Company to exceed the maximum allowable current deduction under the applicable provisions of the Code.

(7) Section 3.5 shall not apply to any Bargaining Unit Member. Notwithstanding the foregoing, with respect to any Bargaining Unit Member employed by Draper Valley Local 21 (Mt. Vernon), Section 3.5 shall read as follows:

3.5 Employer Contributions. Subject to Section 3.8, each Payroll Period a Participating Company shall make Employer Contributions in an amount equal to \$.10 for each Hour of Service an Eligible Employee has performed during such Payroll Period. Employer Contributions shall not be made for non-working Hours of Service, whether paid or unpaid.

(8) Notwithstanding Section 5.8, any Bargaining Unit Member employed by Petaluma Local 8, BCNC Local 1776, or BCNC Local 429 who has a Severance from Employment, and who is entitled to defer the commencement of his benefit, may defer the distribution of that portion of his Account attributable to pre-2013 contributions (adjusted for investment results) to any later date that occurs before his Required Beginning Date. This right constitutes a "protected benefit."

(9) As it applies to any Bargaining Unit Member, Section 6.1 shall read as follows:

6.1 Nonforfeitable Amounts.

(a) A Participant shall have a 100% nonforfeitable interest at all times in his Account, except for his Matching Contribution Account, Former MPP Account, 1% Company Contribution Account (if any), and Discretionary Contribution Account (if any) each of which shall vest in accordance with the following Subsections of this Section 6.1.

(b) A Participant shall have a nonforfeitable interest in his Former MPP Account determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 3 years	0 percent
3 years	30 percent
4 years	40 percent
5 years	60 percent
6 years	80 percent
7 years or more	100 percent

(c) (1) With respect to that portion of his Matching Contribution Account that is attributable to contributions for Plan Years ending on or before December 31, 2004, a Participant shall have a nonforfeitable interest determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 3 years	0 percent
3 years	30 percent
4 years	40 percent
5 years	60 percent
6 years	80 percent
7 years or more	100 percent

(2) With respect to that portion of his Matching Contribution Account that is attributable to contributions

for Plan Years beginning on or after January 1, 2005, a Participant shall have a nonforfeitable interest determined in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 2 years	0 percent
2 years	20 percent
3 years	40 percent
4 years	60 percent
5 years	80 percent
6 years or more	100 percent

(d) Notwithstanding the foregoing, a Participant shall have a 100% nonforfeitable interest in his entire Matching Contribution Account and Former MPP Account if, while an Employee, he attains his Normal Retirement Age, dies, or suffers a Total Disability.

(e) A Bargaining Unit Employee who is employed by Draper Valley Local 21 (Mt. Vernon), shall have a nonforfeitable interest in his Employer Contributions Account in accordance with the following schedule:

<u>Years of Service</u>	<u>Nonforfeitable Interest</u>
less than 2 years	0 percent
2 years	20 percent
3 years	40 percent
4 years	60 percent
5 years or more	100 percent

Notwithstanding Section 6.2(a), prior to January 1, 2013, a Year of Service for purposes of this Section B-2(9)(e) shall mean any twelve month period of service following the Participant's date of hire. All Participants in the Draper Valley Union Plan as of December 31, 2012 shall be credited with one full additional Year of Service in lieu or any period of service of less than one year ending on December 31, 2012.

(10) Withdrawals. With respect to any Bargaining Unit Member employed by Petaluma Local 8, BCNC Local 1776, or BCNC Local 429, Section 9.2(a) shall also be deemed to include that portion of a Participant's Rollover Account (including after-tax rollovers) attributable to pre-2013 contributions (adjusted for investment results). The right of the Participant to withdraw this amount at any time without penalty constitutes a "protected benefit."

(11) Loans. With respect to any Bargaining Unit Member employed by Draper Valley Local 21 (Mt. Vernon), loans shall be permitted from the Employer Contributions

Account. For purposes of Section 10.4, the Employer Contributions Account shall be pledged as security for any loan immediately following the former MPP Account and immediately prior to the Qualified Non-Elective Contribution Account.

THE PERDUE FARMS INC. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN SUMMARY PLAN DESCRIPTION

For associates in these Benefit Groups:

- **2 – Administrative/Technician – Hourly/Non-exempt**
- **3 – Skilled Labor – Hourly/Non-exempt, Piece Rate**
- **4 – General Labor – Hourly/Non-exempt, Piece Rate**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de seguro de vida y por muerte y desmembramiento accidentales de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Effective as of January 1, 2016

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2016, to eligible full-time hourly non-union associates under the Perdue Farms Inc. Life and Accidental Death & Dismemberment (AD&D) Insurance Plan (referred to here simply as “the Plan”), which is a component of the Perdue Farms Inc. Welfare Benefit Plan. This SPD summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior Life and AD&D Insurance Plan SPDs.

A separate SPD exists for associates in Benefit Group 1. If you are in that Benefit Group, contact your local Human Resources (HR) Department for a copy of the SPD that applies to you.

More detailed information is provided in the official plan document and insurance contracts, copies of which are available upon request. If there is a difference between how the SPD and the plan document and insurance contracts describe the eligibility rules and the benefits being provided under the Plan, the plan documents and insurance contracts will control and govern the operation of the Plan.

Perdue Farms Inc. (“the Company”) has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and group insurance contract).

If you have questions regarding your benefits, please call the Corporate Benefits Line at 1-800-997-3247. Participation in the Plan is neither an offer nor a guarantee of future employment.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 37560.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Introduction

The Plan protects you and your family from the financial hardship that may result from the death or serious accidental injury of you or your dependents.

If you are an eligible associate, you are enrolled in Basic Life Insurance coverage automatically. You have the option to enroll in Supplemental Life Insurance and Optional Accidental Death and Dismemberment (AD&D) Insurance for yourself, and for Dependent Life Insurance for your eligible dependent.

The Company pays the cost of Basic Life Insurance. You pay the cost of any other coverage you elect under the Plan on an after-tax basis.

Eligibility

This section outlines the Plan's rules of eligibility for both associates and their dependents to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are an Hourly/Non-exempt associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In one of these Benefit Groups:
 - Benefit Group 2: Administrative/Technician – Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor – Hourly/Non-exempt, Piece Rate
 - Benefit Group 4: General Labor – Hourly/Non-exempt, Piece Rate

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In Benefit Group 1: Salaried/Exempt;
- In a job class covered by a collective bargaining agreement (unless the collective bargaining agreement provides otherwise);
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Eligible Dependents

You may also enroll your eligible dependents in the dependent life insurance component of the Plan. Your eligible dependents are:

- Your legal spouse, including same-sex spouse; and
- Your children from age 7 days to age 26.

Your children include your children by birth or adoption (or placed with you for adoption), stepchildren, and foster children.

You may continue coverage beyond the Plan's maximum age for a dependent child who is unable to earn a living because of a mental or physical disability. You must submit proof of your child's disability to the Plan Administrator within 30 days of the child reaching age 26, and from time to time at the request of the Plan Administrator.

Your spouse or child **is not** your eligible dependent under the Plan if he or she:

- Is on active military duty; or
- Is an eligible associate.

If You and Your Spouse Work for the Company

If you and your spouse both work for the Company and are both eligible associates, you cannot elect “double coverage” for each other or your eligible children under the Plan. Instead, both you and your spouse must make separate enrollment elections for the Plan. Neither of you may cover the other as your dependent spouse.

Either you or your spouse – but not both – may elect coverage for your dependent children.

Protection Against Use of Genetic Information

The Plan will not deny, limit or cancel Plan coverage for you or your eligible dependents based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please call the Corporate Benefits Line at 1-800-997-3247. The Company is the “Claims Fiduciary” for eligibility for the Plan.

Enrollment and Cost

If you want Supplemental Life Insurance and Optional AD&D Insurance coverage for yourself, or Dependent Life Insurance coverage for your eligible dependents, you must enroll. **Only Basic Life Insurance enrollment is automatic.** You pay the full cost of any Supplemental Life Insurance, Dependent Life Insurance and Optional AD&D Insurance you elect on an after-tax basis. The cost of each coverage category is indicated on your personalized enrollment form and is available on the benefits section of Perdue’s intranet site.

Each year during open enrollment, you have the opportunity to make changes to your elections under the Plan. This means any coverage election you make (including no coverage) must remain in effect for up to one year, unless you experience a qualified status change permitting an election change under this Plan or the Perdue Farms Inc. Flexible Benefits Plan. Some change requests require you to provide evidence of insurability.

Newly-Hired Associates

The following sections outline the steps required to enroll in the Plan and the dates when your coverage under the Plan begins for newly-hired associates.

When and How to Enroll

When you start working for the Company, you will be provided with an enrollment package. The package will include information about your coverage options, their costs, enrollment forms and instructions and the date by which you must make your elections.

You must complete, sign and return your enrollment forms (including any supporting documentation or proof required to be provided) to your HR Department by the dates outlined in your enrollment materials in order to be covered under the Plan.

When Your Coverage Begins

Coverage begins on the first day of the calendar month on or after the day you complete 60 days of employment with the Company, if you return your enrollment forms by the date specified in your enrollment materials and are “actively at work” on the date coverage is scheduled to begin.

If you elect Supplemental Life Insurance in an amount over \$40,000, coverage of \$40,000 will begin on the first day of the calendar month on or after the day you complete three months of full-time employment with the Company, if you return your enrollment forms by the date specified in your enrollment materials and are “actively at work” on the date coverage is scheduled to begin. Coverage for the amount above \$40,000 begins on the date your evidence of insurability is approved (if approved).

What Does “Actively at Work” Mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer’s place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day. If you were absent from work due to a health-related factor, you will be considered “actively at work” for this purpose.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

When Dependent Coverage Begins

Coverage for any eligible dependents you elect to enroll begins on the same day your own coverage begins. But if your dependent is confined to home or anywhere else for medical care on the date Dependent Life Insurance coverage is scheduled to begin, your dependent’s coverage will be delayed until your dependent fully recovers.

If you enroll your eligible child for Dependent Life Insurance coverage, the Plan will automatically cover any other children who become your eligible dependent(s).

Waiving Coverage

You may elect to waive Supplemental Life Insurance, Optional AD&D Insurance, and/or Dependent Life Insurance coverage under the Plan by completing the appropriate section on your enrollment form and returning it to your HR Department.

Current Associates – Add or Change Existing Coverage

If you do not enroll for Supplemental Life Insurance, Optional AD&D Insurance and/or

Dependent Life Insurance coverage when you are first eligible, or if you enroll and later want to change your coverage for Basic Life Insurance or the coverages above, you may enroll or make changes to these coverages only:

- During an open enrollment period in which Plan coverage is offered; or
- After a qualified status change permitting an election change under this Plan.

An application to add or increase Basic, Supplemental or Dependent Life Insurance coverage requires you to provide “evidence of insurability” for the applicant, as described in the section “Evidence of Insurability for Life Insurance.” When the change or addition is approved, you must be actively at work in order for the change or addition to take effect.

Open Enrollment – Additions, Deletions or Changes

During the annual open enrollment period, your enrollment package will include information about the coverage options available to you under the Plan. At that time, you will have an opportunity to select the coverage that best meets your needs for the coming year.

If you meet the eligibility rules, you may add or drop coverage for yourself and/or your eligible dependents during this open enrollment period.

In order to add, drop or change your coverage during the annual open enrollment period, you must complete, sign and return your enrollment forms (including any supporting documentation or proof required) to your HR Department by the dates outlined in your open enrollment materials. Plan elections or changes you make during the annual open enrollment period take effect on the first day of the following calendar year, for both you and your eligible dependents. If you do not elect to make any changes, your current coverage option will continue.

If you apply to add or increase Basic, Supplemental or Dependent Life Insurance coverage, you must provide “evidence of insurability” for the person to be insured, as described in the next section. When the change or addition is approved, you must be actively at work in order for the change or addition to take effect.

Evidence of Insurability for Life Insurance

If evidence of insurability (EOI) is required, you must provide health and financial information to the Claims Administrator. The Claims Administrator reviews the information to determine whether your application will be approved. In some cases, providing evidence of insurability may require a physical examination by a doctor.

Qualified Status Changes Permitting an Election Change

You may change your coverage or add eligible dependents during the year if you have a qualified status change that permits you to change your election under the Plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is on account of, and corresponds with, the change in status event.

A qualified status change is defined as a change in status that affects your coverage, including the events listed in the following chart:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death. The eligibility status of one dependent affected does not necessarily allow enrolling or dropping enrollment for other dependents.
Work Schedule	A reduction in hours of employment by you or your spouse from full-time to part-time, or where you or your spouse take an unpaid leave of absence.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet the Plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage, change in student status or any similar circumstance.
Employment or Termination of Employment	You or your spouse gains or loses employment, or a significant change in your health coverage that is attributed to your spouse's employment.

Any change you make must be consistent with the actual event (for example, if you get married, you may enroll your spouse). In order to make a change, you must complete, sign and return an enrollment form to the HR Department within 30 days of the date of the qualifying family status change (for example, dependent birth date, date of marriage). You must provide proof of the qualifying event (for example, a marriage or dependent birth certificate).

If you change your coverage within 30 days of a qualified family status change, your change is effective as of the date the family status change occurs, or when your evidence of insurability is accepted by the Claims Administrator (if applicable). If you miss the deadline, you must wait until the next open enrollment period in which Plan coverage is offered to request a change.

Your Cost

The Company pays the cost of Basic Life Insurance coverage. You pay the full cost of any Supplemental and Dependent Life Insurance and Optional AD&D Insurance coverage you elect under the Plan. Your payroll deduction amount appears on your pay statement. In addition, cost information for all the available options is provided in your initial enrollment package and in the enrollment material distributed each year during open enrollment.

Your contributions for Supplemental Life Insurance, Dependent Life Insurance and Optional AD&D Insurance coverage are deducted from your pay on an after-tax basis. This means that any benefits payable under the Plans will not be taxable to you.

How Life and AD&D Insurance Benefits Are Paid

The Plan pays benefits to the beneficiary named for each option. You may change your beneficiary at any time unless you have assigned your benefits.

Naming a Beneficiary

When you enroll, you submit a beneficiary designation form to your HR Department. Since Basic Life Insurance coverage is automatic, it is important to submit this form even if you do not elect any Supplemental, Dependent or Optional coverage. You may choose one or more individuals, your estate, almost any organization or a trust as your beneficiary. Your beneficiary designation takes effect on the date the properly completed form is received.

You may elect a different beneficiary for each coverage option. *You* are automatically the beneficiary for any Dependent Life Insurance coverage you elect under the Plan.

If you name more than one beneficiary, be sure to indicate the share payable to each one. If you do not indicate this, your beneficiaries will share equally.

If none of your beneficiaries are living when you die, or no beneficiaries are named, death benefits are paid in the following order:

- Your surviving spouse;
- Your surviving child(ren) in equal shares;
- Your surviving parent(s) in equal shares;
- Your surviving sibling(s) in equal shares; or
- Your estate.

Different rules apply if you assign your benefits (see “Benefits Can Be Assigned”).

Special rules may apply if your elected beneficiary is under age 18. Please contact your HR Department for more information regarding these rules.

Changing Your Beneficiary

You may change your beneficiary at any time unless you have assigned your benefits (see “Benefits Can Be Assigned”). To change your beneficiary, get a beneficiary change form from your HR Department, complete the form and return it to that Department. Once the form is received, the change is effective as of the date you signed it.

Benefits Can Be Assigned

You may assign your Basic Life Insurance, Optional Life Insurance, Dependent Life Insurance and Optional AD&D Insurance as an irrevocable gift to someone else if the Claims Administrator consents. You may name that person as the owner of your insurance, even though it is your life that is insured. By definition, an irrevocable gift is permanent and cannot be changed or withdrawn once it is made.

If you make an assignment, you give up all present and future rights to the insurance. You cannot revoke the assignment at a later date. The person to whom you assign your insurance

has the right to name beneficiaries, to change the level of coverage or to exercise any other privileges under the insurance that would otherwise have been available to you.

Because of the various legal and tax implications involved, you may wish to consult with a lawyer and a tax advisor before making an assignment. If you wish to assign your benefits, call the Corporate Benefits Line at 1-800-997-3247.

A Quick Look at the Options

Here are the options for each type of coverage offered by the Plan.

Basic Life Insurance – For eligible associates, paid for by the Company

- \$10,000; or
- \$20,000.

Optional Life Insurance – For eligible associates, paid for by the associate

- \$10,000;
- \$20,000;
- \$30,000;
- \$40,000;
- \$50,000;
- \$75,000; or
- \$100,000.

Maximum Optional Life Insurance coverage is \$100,000. Coverage options of more than \$40,000 require evidence of insurability.

Optional AD&D Insurance – For eligible associates, paid for by the associate

- \$10,000;
- \$20,000;
- \$30,000;
- \$40,000; or
- \$50,000.

Maximum Optional AD&D Insurance coverage is \$50,000.

Dependent Life Insurance – For eligible spouse, paid for by the associate

- \$5,000; or
- \$10,000.

Dependent Life Insurance – For eligible children, paid for by the associate

- \$2,500 (\$1,000 from age 7 days through 11 months); or
- \$5,000 (\$2,000 from age 7 days through 11 months).

Basic Life Insurance

Basic Life Insurance is provided at no cost. The Company pays all premiums.

Basic Life Insurance Coverage Options

You may choose one of the following Basic Life Insurance coverage options:

- Option 1 - a death benefit of \$10,000; or
- Option 2 - a death benefit of \$20,000.

If you elect Option 1, you will receive in your paycheck an amount equal to the difference in premium between Option 1 and Option 2.

When Evidence of Insurability Is Required

You do not need to provide EOI when your Basic Life Insurance coverage begins. If you apply for an increase in your coverage option – such as moving from Option 1 to Option 2 – you must provide EOI with your application. See the section “Evidence of Insurability for Life Insurance” for details.

Limits on Coverage

The Plan limits the amount of Basic Life Insurance coverage you may have before and after age 65.

Maximum Dollar Limit

The amount of your Basic Life Insurance coverage under the Plan cannot exceed \$20,000.

Reductions at Age 65

The amount of your Basic Life Insurance coverage reduces by 35% when you reach 65 years of age. This reduction takes place on the January 1st that occurs on or after your 65th birthday.

Optional Life Insurance

Optional Life Insurance is offered to eligible associates on a voluntary basis. If you choose this coverage, you pay all premiums on an after-tax basis.

Optional Life Insurance Coverage Options

You may select one of the following options, or you may decline coverage.

- \$10,000;
- \$20,000;
- \$30,000;
- \$40,000;
- \$50,000;
- \$75,000; or
- \$100,000.

When Evidence of Insurability Is Required

You must provide evidence of insurability for your Optional Life insurance if:

- You elect Optional Life insurance more than 30 days after your initial eligibility date;
- You elect Optional Life insurance of \$40,000 or more;
- You drop all or some of your Optional Life insurance coverage and decide to elect coverage again at a later date;
- You previously submitted required evidence of insurability and were denied coverage; or
- Your previous coverage ends due to non-payment of premiums.

See the “Evidence of Insurability for Life Insurance” section for details.

Limits on Coverage

The Plan limits the amount of Optional Life Insurance coverage you may have before and after age 65.

Maximum Coverage Dollar Amount

Your Optional Life Insurance coverage under the Plan is limited to \$100,000.

Reductions at Age 65

The amount of your Optional Life Insurance coverage reduces by 35% when you reach 65 years of age. This reduction takes place on the January 1st that occurs on or after your 65th birthday.

Dependent Life Insurance

Dependent Life Insurance is offered to eligible associates on a voluntary basis. If you choose this coverage, you pay all premiums on an after-tax basis.

Dependent Life Insurance Coverage Options

You may select one option for your spouse and/or one option for your children, or you may decline either or both coverages.

Dependent Life Insurance for Your Spouse

- Option 1 – a death benefit of \$5,000; or
- Option 2 – a death benefit of \$10,000.

Dependent Life Insurance for Your Children

The option you choose applies to all your eligible dependent children. The cost you pay covers all your eligible children.

- Option 3 – a death benefit of \$2,500; or
- Option 4 – a death benefit of \$5,000.

Limits on Coverage

The Plan limits Dependent Life Insurance coverage for children between the ages of seven days to 12 months of age as follows:

- Option 3 – death benefit is limited to \$1,000; and
- Option 4 – death benefit is limited to \$2,000.

When Evidence of Insurability Is Required

You must provide evidence of insurability for Dependent Life Insurance for your spouse only if:

- You elect Dependent Life Insurance more than 30 days after your spouse's initial eligibility date (such as when you first become eligible for the Plan, or when you marry);
- You apply to increase Dependent Life Insurance coverage for your spouse, such as from Option 1 to 2;
- You drop all or some of your Dependent Life Insurance coverage for your spouse and decide to elect coverage again at a later date;
- You previously submitted required evidence of insurability and your spouse was denied coverage; or
- Your spouse's previous coverage ends due to non-payment of premiums.

No evidence of insurability is required for Dependent Life Insurance for your children.

See the section "Evidence of Insurability for Life Insurance" for details.

Optional AD&D Insurance

Optional AD&D Insurance is offered to eligible associates on a voluntary basis. If you choose this coverage, you pay all premiums on an after-tax basis.

Optional AD&D Insurance Coverage Options

You may choose from one of the options, or you may decline coverage.

- 10,000;
- \$20,000;
- \$30,000;
- \$40,000; or
- \$50,000.

Evidence of insurability is not required for Optional AD&D Insurance.

How Optional AD&D Insurance Pays Benefits

If you elect Optional AD&D Insurance, the Plan pays a benefit only when a qualifying accident is the sole cause of a “covered loss.” This chart shows the Plan’s covered losses for AD&D Insurance and the benefit paid for each. Unless shown differently in the chart, you must suffer the covered loss within 90 days after your qualifying accident.

Covered Loss	AD&D Benefit	Notes/Definitions
Life	100% of AD&D coverage amount to your beneficiary(ies)	
Both hands or both feet	100% of AD&D coverage amount to you	Actual severance of foot at or above ankle. Actual severance at or above the wrist, or of thumb and finger at or above the knuckles joining each to hand (metacarpophalangeal joint).
One hand <i>and</i> one foot	100% of AD&D coverage amount to you	
One hand <i>or</i> one foot	50% of AD&D coverage amount to you	
Thumb and index finger of same hand	25% of AD&D coverage amount to you	
Sight of both eyes	100% of AD&D coverage amount to you	Total and permanent loss of sight in one or both eyes.
Sight of one eye	50% of AD&D coverage amount to you	
Sight of one eye <i>and</i> ; <ul style="list-style-type: none">• One hand; or• One foot	100% of AD&D coverage amount to you	As defined above.
Speech <i>and</i> hearing	100% of AD&D coverage amount to you	Total and permanent loss of speech. Total and permanent loss of hearing in both ears.
Speech	50% of AD&D coverage amount to you	

Covered Loss	AD&D Benefit	Notes/Definitions
Hearing	50% of AD&D coverage amount to you	
Quadriplegia	100% of AD&D coverage amount to you	Complete and irreversible paralysis of upper and lower limbs within 365 days of accident.
Paraplegia	75% of AD&D coverage amount to you	Complete and irreversible paralysis of both lower limbs within 365 days of accident.
Hemiplegia	50% of AD&D coverage amount to you	Complete and irreversible paralysis of upper and lower limbs on one side of the body within 365 days of accident.

Additional Death Benefits

The Plan offers these additional benefits when a covered loss results in your death.

Seat Belt Benefit

If a covered loss results in your death while you are in a four-wheel vehicle *and* you are properly wearing a factory-installed seat belt, the Plan pays its seat belt benefit in addition to its death benefit. The seat belt benefit is the lesser of:

- 10% of your AD&D coverage amount; or
- \$10,000.

Verification of the use of the seat belt must be part of the official report of the accident, or it must be certified in writing by the investigating officer.

Supplemental Restraint System Benefit

If a covered loss results in your death while you are in a four-wheel vehicle and the vehicle's factory-installed supplemental restraint system (such as an air bag) deploys, the Plan pays its supplemental restraint system benefit in addition to its death benefit. The supplemental restraint system benefit is the lesser of:

- 10% of your AD&D coverage amount; or
- \$10,000.

Verification of the deployment of the supplemental restraint system must be part of the official report of the accident, or it must be certified in writing by the investigating officer.

Limits on Coverage and Benefits

The Plan limits the amount of Optional AD&D Insurance coverage you may have before and after age 65. The Plan also limits the total amount paid for losses stemming from a single accident.

Maximum Coverage Dollar Amount

The amount of your Optional AD&D Insurance coverage under the Plan cannot exceed \$50,000.

Reductions at Age 65

The amount of your Optional AD&D Insurance coverage reduces by 35% when you reach 65 years of age. This reduction takes place on the January 1st that occurs on or after your 65th birthday.

Benefit Limits for Multiple Covered Losses

If a single accident results in more than one covered loss, your total benefit from the Plan is limited to 100% of your AD&D coverage amount.

What Is Not Covered

There are some losses that are not covered under Optional AD&D insurance. Specifically, no benefits are paid for accidental death or losses caused by:

- Suicide or attempted suicide while sane or insane;
- Injuring or attempting to injure yourself on purpose;
- Sickness (regardless of whether the loss is a direct or indirect result of the sickness);
- Medical treatment of an illness or surgical procedure;
- An infection (unless it is a pyogenic infection caused by an external visible wound as a result of an accident or a bacterial infection caused by accidental ingestion of a contaminated substance);
- War or any act of war ("war" means declared or undeclared war and includes resistance to armed aggression);
- An accident that occurs while on full time active military duty for more than 30 days in any armed forces (except for Reserve or National Guard active duty for training);
- Travel or flight in any vehicle used for aerial navigation (includes getting in, out, on or off any such vehicle) if you are:
 - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - Performing as a pilot or a crew member of any aircraft, other than an aircraft owned leased or operated by the Company; or
 - Riding as a passenger in an aircraft owned, leased, or operated by the Company.
- Your commission or attempted commission of a felony;
- Being legally intoxicated or under the influence of any narcotic (unless administered on the advice of a doctor); or
- Participation in any of the following hazardous sports: scuba diving, bungee jumping, skydiving, parachuting, hang gliding or ballooning.

The Claims Administrator determines whether benefits will be paid.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

If You Are on an Approved Leave of Absence or Approved Disability Leave

Continuing Coverage During Your Leave

If you are on an approved leave of absence (including a leave under the Family and Medical Leave Act) or approved disability leave, your Plan coverage may continue.

- If you are on an approved, **paid** leave (you receive compensation directly from the Company), your Basic Life Insurance (Company-paid) will continue during your leave. Your Optional and Dependent Life Insurance and Optional AD&D Insurance will also continue, and premiums for your Plan coverage will continue to be deducted from your paycheck.
- If you are on an approved, **unpaid medical** leave (you receive either no compensation or you receive compensation from a source other than the Company, such as from a group plan or individual disability insurance policy), your Basic Life Insurance (Company-paid) will continue during your leave, so long as you remain an active associate of the Company. Your Optional and Dependent Life Insurance and Optional AD&D Insurance will also continue during your leave, so long as you remain an active associate of the Company *and* you pay premiums for your Plan coverage. The HR Department will send you a letter detailing the payment arrangements.
- If you are on an approved, **unpaid personal** leave (you receive no compensation from the Company), your Basic Life Insurance coverage ends 30 days after your unpaid personal leave begins. Your Optional and Dependent Life Insurance and Optional AD&D Insurance will also continue during your leave, so long as you remain an active associate of the Company *and* you pay the required premiums. The HR Department will send you a letter detailing the payment arrangements.

If you choose to continue Plan coverage during your leave, but you terminate your employment or fail to return from leave and your employment is terminated, your coverage ends on the date on which your employment terminates or on the date your premiums ended, whichever is earlier. You may be able to convert all or part of your Basic, Optional and/or Dependent Life Insurance to an individual policy when these coverages end. (See “Converting Coverage to an Individual Policy.”)

Approved Leave of Absence Under Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of life and AD&D insurance coverage and re-employment in regard to your military leave of absence. These requirements apply to coverage under the Plan for you and your eligible dependents.

Continuation of Coverage – If you are on an approved military leave of absence, your coverage under the Plan may continue, as long as you make any required premium contributions. For leaves of 31 days or more, you may continue coverage for yourself and your

eligible dependents. You continue coverage by paying the required premiums to the Company, until the earliest of the following:

- 24 months from the last day of employment with the Company;
- The day after you fail to return to work; and
- The date the Plan ends.

Reinstatement of Coverage – If your coverage ends during the leave of absence because you do not elect USERRA continuation coverage and you are re-employed by the Company, coverage for you and your eligible dependents under the Plan may be reinstated if:

- You gave the Company advance written or verbal notice of your military service leave; and
- The duration of all military leaves while you are employed with the Company does not exceed two years.

If You Terminate Your Employment

Your coverage under the Plan ends on the day your employment terminates, whether or not your termination was due to your failure to return from a leave of absence. When coverage ends, you may be eligible to convert all or part of your Basic, Optional and/or Dependent Life Insurance to an individual policy when these coverages end. (See “Converting Coverage to an Individual Policy.”)

If You Gain a New Dependent

If you gain a new dependent (for example, through marriage, birth or adoption), you may enroll him or her for Dependent Life coverage if you do so within 30 days of the date he or she becomes your eligible dependent. You must provide the Company with any documentation that may be required to verify the person’s status as your dependent.

If a Dependent Loses Eligibility

If a dependent no longer meets the eligibility requirements, he or she may be able to elect portability or convert all or part of his or her Dependent Life Insurance to an individual policy when that coverage ends. (See “When Coverage Ends” for details.)

If You Die

If you die, coverage for your dependents ends. However, your eligible covered dependents may be able to elect portability or convert all or part of their Dependent Life Insurance to an individual policy when that coverage ends. (See “When Coverage Ends” for details.)

If You Become Terminally Ill

If you are diagnosed as being terminally ill with a life expectancy of six months or less, **the accelerated payment option** allows you to receive a portion of your Basic and Optional Life Insurance benefit from the Plan before you die. You may request any amount up to the lower of \$100,000 or 50% of your combined Basic and Optional Life Insurance benefit. You may use this money in any way you wish.

The accelerated payment option is not available for Dependent Life Insurance or Optional AD&D Insurance.

The accelerated payment option you receive reduces both the amount of death benefit payable to your beneficiary and the amount of coverage available to you for conversion or portability. The accelerated payment benefit you receive may be taxable to you; please consult a professional tax advisor before you apply for this option.

Here are some guidelines that may affect your eligibility or decision to apply for this benefit:

- You are not eligible for the accelerated payment option if you previously assigned your life insurance coverage (see “Benefits Can Be Assigned”).
- You must submit satisfactory proof to the insurance company that you are terminally ill, including certification by a doctor.
- If your Basic and Optional Life Insurance coverage is scheduled to be reduced within six months of the date your request is received, your accelerated payment option is limited to 50% of the reduced coverage amount.
- Accelerated benefit payments may affect your eligibility for benefits under state and federal law.

Claims

You or your beneficiary must file a claim to apply for benefits or to request the accelerated payment option.

Filing a Claim For Life Insurance or AD&D Insurance Benefits

To report a death or other covered loss, you (or your beneficiary, if you die) should call the Corporate Benefits Line at 1-800-997-3247. You (or your beneficiary) will be sent all the necessary claim forms to complete.

To file a claim:

- Call to report the death or loss.
- Follow the instructions on the claim form carefully and answer all questions completely.
- If you are filing a claim for death benefits, attach the death certificate.
- Submit the required paperwork as directed on the forms.
- In addition, the following applies for Optional AD&D Insurance claims:
 - While a claim for accidental dismemberment benefits is pending, the Claims Administrator has the right to appoint a physician to examine you as often as it may reasonably require.
 - For accidental death claims, the Claims Administrator also has the right to have an autopsy made, where it is not forbidden by law.

The Claims Administrator evaluates all claims to determine if any benefits will be paid. If the claim is approved, payment will be made. If any benefits are denied, a written explanation will be sent. If there is a question about a claim payment, you or your beneficiary(ies) may request an explanation from the Claims Administrator.

If a claim is denied, you or your beneficiary(ies) may appeal the decision (see “Claim Denial and Appeal Procedures”).

Filing a Claim for the Accelerated Payment Option (Basic and Optional Life Insurance Only)

To request the accelerated payment option, call the Corporate Benefits Line at 1-800-997-3247 for the necessary forms to complete.

AD&D Insurance Filing Deadline

You should submit claims for AD&D Insurance benefits within 90 days after the date of the loss. If it is not reasonably possible to provide proof within this time frame, an extension may be granted if you (or your beneficiary) can prove you furnished the proof as soon as reasonably possible.

Other Important Claims Information

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Claim Determination Procedures

The Claims Administrator – Prudential – will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- A description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the

appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:

- The specific reason(s) for the adverse determination;
- References to the specific Plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
- A description of Prudential's review procedures and applicable time limits;
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential will make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

When Coverage Ends

This section outlines when coverage ends, and your options for continuing coverage.

When Associate Coverage Ends

Your Basic Life Insurance, Optional Life Insurance and Optional AD&D Insurance end on the earliest date one of the following events occur:

- You stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Perdue Incorporated life insurance benefits or benefit is terminated; or
- You fail to pay any required premiums (not eligible for portability or conversion).

When Dependent Coverage Ends

Dependent Life Insurance ends on the date your own life insurance coverage ends, or it may also end on the earliest date that one of the following events occur:

- Your covered dependent is no longer eligible;
- The Plan is terminated; or
- You fail to pay any required premiums.

Portability

Your Optional Life Insurance, Dependent Life Insurance and Optional AD&D Insurance include a portability provision. This allows you and your covered dependents to continue insurance coverage. You may not elect portability for your Basic Life Insurance.

You must elect portability for your Optional Life Insurance in order for your covered spouse and/or children to elect portability for their Dependent Life Insurance. However, your dependents can elect portability if their coverage ends due to divorce or your death.

Generally, you and your covered dependents can elect portability if:

- You and your spouse are under age 80;
- Your covered children are under age 26; and
- You are actively at work on the date before employment ends (exception made if you are disabled associates).

Generally, you and your covered dependents cannot elect portability if:

- Contributions are not up to date;
- The dependent is confined for medical care or treatment, either at home or elsewhere, on the date your life insurance coverage ends;
- The Plan ends and is replaced by another group plan within 31 days.

These limits apply to the amount of Optional Life Insurance, Dependent Life Insurance and Optional AD&D Insurance available for portability:

- Minimum: \$20,000 for Optional Life and Optional AD&D Insurance; for Dependent Life Insurance, the amount of coverage in effect when coverage terminates;
- Maximum: The lesser of:
 - Five times your annual earnings; or
 - \$1 million.
- You may not port an amount of Optional AD&D Insurance that is more than the amount of Optional Life Insurance you port.

If your Optional Life Insurance is greater than the maximum amount shown above, you may convert the difference, as described below.

Converting Coverage to an Individual Policy

You may convert all or part of your Basic, Optional and/or Dependent Life Insurance to an individual policy when that coverage ends. You may not convert your Optional AD&D Insurance.

Conversion is not available if:

- Contributions are not up to date;
- The Basic, Optional and/or Dependent Life Insurance is terminated for all members in your employment class, and you have maintained this coverage for less than five years at termination.

To convert your eligible coverages, you must request the conversion within a specific period, which is the later of:

- 31 days after your coverage ends; or
- 15 days after you receive written notice of your right to choose conversion (but no later than 92 days after your coverage ends).

No evidence of insurability is required during this period. If an eligible person dies during this conversion period, the beneficiary will receive the full amount of the life insurance available for conversion.

The individual policy will be one customarily issued by the Claims Administrator for conversions. If you are interested in converting your insurance, call the Corporate Benefits Line at 1-800-997-3247.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants will be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should

happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Plan is fully-insured through an insurance contract with The Prudential Insurance Company of America ("Prudential"). The Company pays the costs associated with providing you with Basic Life Insurance. You pay the full cost for any Optional Life Insurance, Dependent Life Insurance or Optional AD&D Insurance you elect. Any costs you pay for coverage go toward the total premium paid by the Company to Prudential.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an "at-will employee," either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the Plan document, including the group insurance contract, that determines your rights and the rights of your dependents under the Plan. If there is a discrepancy between this summary plan description and the Plan document, including the group insurance contract, the Plan document, including the group insurance contract, will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan, the group insurance contract, or other documents maintained in conjunction with the Plan.

Benefits Provided by Group Contract

The life insurance and AD&D insurance benefits in the Plan are governed by a group insurance contract, underwritten by The Prudential Insurance Company of America (Prudential), and provide insured benefits under Plan. Prudential as Claims Administrator has the sole discretion to interpret the terms of the group insurance contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator will not be overturned unless arbitrary and capricious.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the Plan document, including the group insurance contract). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan will be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Life and AD&D Insurance Plan Identification

Plan Name	The official Plan name is the Perdue Farms Inc. Life and Accidental Death and Dismemberment Insurance Plan.
Plan Sponsor	The Plan Sponsor is Perdue Incorporated.
Type of Administration	The life and AD&D insurance benefits under the Plan are administered by an insurance contract with The Prudential Insurance Company of America.
Plan Administrator	The Plan Administrator is: The Perdue Benefits Committee Perdue Farms Inc. 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Insurer/Claims Administrator	The insurer/Claims Administrator is: The Prudential Insurance Company of America 80 Livingston Avenue Roseland, NJ 07068 The group insurance contract number is G-37560.
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Farms Inc. Life and Accidental Death & Dismemberment Insurance Plan is: Perdue Farms Inc. 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.
Plan Records and Plan Year	The Perdue Farms Inc. Life and Accidental Death and Dismemberment Insurance Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Farms Inc. Life and Accidental Death and Dismemberment Insurance Plan, which is a component of the Perdue Incorporated Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 502.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

THE PERDUE FARMS INC. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN SUMMARY PLAN DESCRIPTION

**For non-union associates in
Benefit Group 1 — Salaried/Exempt**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de seguro de vida y por muerte y desmembramiento accidentales de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Effective as of January 1, 2016

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2016, to eligible full-time non-union associates under the Perdue Farms Inc. Life and Accidental Death & Dismemberment (AD&D) Insurance Plan (referred to here simply as "the Plan"), which is a component of the Perdue Farms Inc. Welfare Benefit Plan. This SPD summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior Plan SPDs.

A separate SPD exists for associates in Benefit Groups 2 through 4. If you are in one of those Benefit Groups, contact your local Human Resources (HR) Department for a copy of the SPD that applies to you.

More detailed information is provided in the official plan document and insurance contracts, copies of which are available upon request. If there is a difference between how the SPD and the plan document and insurance contracts describe the eligibility rules and the benefits being provided under the Plan, the plan documents and insurance contracts will control and govern the operation of the Plan.

Perdue Farms Inc. ("the Company") has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and group insurance contract).

If you have questions regarding your benefits, please call the Corporate Benefits Line at 1-800-997-3247. Participation in the Plan is neither an offer nor a guarantee of future employment.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 37560.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Introduction

The Plan protects you and your family from the financial hardship that may result from the death or serious accidental injury of you or your dependents.

If you are an eligible associate, you are enrolled in Basic Life Insurance coverage automatically. You have the option to enroll in Supplemental Life Insurance and Optional Accidental Death and Dismemberment (AD&D) Insurance for yourself, and for Dependent Life Insurance for your eligible dependent.

The Company pays the cost of Basic Life Insurance. You pay the cost of any other coverage you elect under the Plan on an after-tax basis.

Eligibility

This section outlines the Plan's rules of eligibility for both associates and their dependents to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are a Salaried/Exempt associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In Benefit Group 1: Salaried/Exempt
-

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In one of these Benefit Groups:
 - Benefit Group 2: Administrative/Technician - Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor - Hourly/Non-exempt, Piece Rate
 - Benefit Group 4: General Labor - Hourly/Non-exempt, Piece Rate
- In a job class covered by a collective bargaining agreement;
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Eligible Dependents

You may also enroll your eligible dependents in the Plan. Your eligible dependents are:

- Your legal spouse, including same-sex spouse; and
- Your unmarried dependent children from age 7 days to age 26. .

Your children include your children by birth or adoption (or placed with you for adoption), stepchildren, and foster children.

You may continue coverage beyond the Plan's maximum age for a dependent child who is unable to earn a living because of a mental or physical disability. You must submit proof of your child's disability to the Plan Administrator within 30 days of the child reaching age 26, and from time to time at the request of the Plan Administrator.

Your spouse or child **is not** your eligible dependent under the Plan if he or she:

- Is on active military duty; or
- Is an eligible associate.

If You and Your Spouse Work for the Company

If you and your spouse both work for the Company and are both eligible associates, you cannot elect "double coverage" for each other or your eligible children under the Plan. Instead, both you and your spouse must make separate enrollment elections for the Plan. Neither of you may cover the other as your dependent spouse.

Either you or your spouse - but not both - may elect coverage for your dependent children.

Protection Against Use of Genetic Information

The Plan will not deny, limit or cancel Plan coverage for your or your eligible dependents based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please call the Corporate Benefits Line at 1-800-997-3247. The Company is the "Claims Fiduciary" for eligibility for the Plan.

Enrollment and Cost

If you want Supplemental Life Insurance and Optional AD&D Insurance coverage for yourself, or Dependent Life Insurance coverage for your eligible dependents, you must enroll. **Only Basic Life Insurance enrollment is automatic.** You pay the full cost of any Supplemental Life Insurance, Dependent Life Insurance and Optional AD&D Insurance you elect on an after-tax basis. The cost of each coverage category is indicated on your personalized enrollment form and is available on the benefits section of Perdue's intranet site.

Each year during open enrollment, you have the opportunity to make changes to your elections under the Plan. This means any coverage election you make (including no coverage) must remain in effect for up to one year, unless you experience a qualified status change permitting an election change under this Plan or the Perdue Farms Inc. Flexible Benefits Plan. Some change requests require you to provide evidence of insurability.

Newly-Hired Associates

The following sections outline the steps required to enroll in the Plan and the dates when your coverage under the Plan begins for newly-hired associates.

When and How to Enroll

When you start working for the Company, you will be provided with an enrollment package. The package will include information about your coverage options and their costs, enrollment forms and instructions and the date by which you must make your elections.

You must complete, sign and return your enrollment forms (including any supporting documentation or proof required to be provided) to your HR Department by the dates outlined in your enrollment materials in order to be covered under the Plan.

When Your Coverage Begins

Coverage begins on the first day of the calendar month on or after your first day of employment with the Company, if you return your enrollment forms by the date specified in your enrollment materials and are "actively at work" on the date coverage is scheduled to begin.

What Does "Actively at Work" Mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer's place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day. If you were absent from work due to a health-related factor, you will be considered "actively at work" for this purpose.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

When Dependent Coverage Begins

Coverage for any eligible dependents you elect to enroll begins on the same day your own coverage begins. But if your dependent is confined to home or anywhere else for medical care on the date Dependent Life Insurance coverage is scheduled to begin, your dependent's coverage will be delayed until your dependent fully recovers.

If you enroll your eligible child for Dependent Life Insurance coverage, the Plan will automatically cover any other children who become your eligible dependent(s).

Waiving Coverage

You may elect to waive Supplemental Life Insurance, Optional AD&D Insurance, and/or Dependent Life Insurance coverage under the Plan by completing the appropriate section on your enrollment form and returning it to your HR Department.

Current Associates — Add or Change Existing Coverage

If you do not enroll for Supplemental Life Insurance, Optional AD&D Insurance and/or Dependent Life Insurance coverage when you are first eligible, or if you enroll and later want to change your coverage for Basic Life Insurance or the coverages above, you may enroll or make changes to these coverages only:

- During an open enrollment period in which Plan coverage is offered; *or*
- After a qualified status change permitting an election change under this Plan.

An application to add or increase Basic, Supplemental or Dependent Life Insurance coverage requires you to provide "evidence of insurability" for the applicant, as described in the section "Evidence of Insurability for Life Insurance." When the change or addition is approved, you must be actively at work in order for the change or addition to take effect.

Open Enrollment — Additions, Deletions or Changes

During the annual open enrollment period, your enrollment package will include information about the coverage options available to you under the Plan. At that time, you will have an opportunity to select the coverage that best meets your needs for the coming year.

If you meet the eligibility rules, you may add or drop coverage for yourself and/or your eligible dependents during this open enrollment period.

In order to add, drop or change your coverage during the annual open enrollment period, you must complete, sign and return your enrollment forms (including any supporting documentation

or proof required) to your HR Department by the dates outlined in your open enrollment materials. Plan elections or changes you make during the annual open enrollment period take effect on the first day of the following calendar year, for both you and your eligible dependents. If you do not elect to make any changes, your current coverage option will continue.

If you apply to add or increase Basic, Supplemental or Dependent Life Insurance coverage, you must provide "evidence of insurability" for the person to be insured, as described in the next section. When the change or addition is approved, you must be actively at work in order for the change or addition to take effect.

Evidence of Insurability for Life Insurance

If evidence of insurability (EOI) is required, you must provide health and financial information to the Claims Administrator. The Claims Administrator reviews the information to determine whether your application will be approved. In some cases, providing evidence of insurability may require a physical examination by a doctor.

Qualified Status Changes Permitting an Election Change

You may change your coverage or add eligible dependents during the year if you have a qualified status change that permits you to change your election under the Plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is on account of, and corresponds with, the change in status event.

A qualified status change is defined as a change in status that affects your coverage, including the events listed in the following chart:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death. The eligibility status of one dependent affected does not necessarily allow enrolling or dropping enrollment for other dependents.
Work Schedule	A reduction in hours of employment by you, or your spouse, from full-time to part-time, or where you or your spouse take an unpaid leave of absence.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet the Plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage, change in student status or any similar circumstance.
Employment or Termination of Employment	You or your spouse gains or loses employment, or a significant change in your health coverage that is attributed to your spouse's employment.

Any change you make must be consistent with the actual event (for example, if you get married, you may enroll your spouse). In order to make a change, you must complete, sign and return an enrollment form to the HR Department within 30 days of the date of the qualifying family status change (for example, dependent birth date, date of marriage). You must provide proof of the qualifying event (for example, a marriage or dependent birth certificate).

If you change your coverage within 30 days of a qualified family status change, your change is effective as of the date the family status change occurs, or when your evidence of insurability is accepted by the Claims Administrator (if applicable). If you miss the deadline, you must wait until the next open enrollment period in which Plan coverage is offered to request a change.

Your Cost

The Company pays the cost of Basic Life Insurance coverage. You pay the full cost of any Supplemental and Dependent Life Insurance and Optional AD&D Insurance coverage you elect under the Plan. Your payroll deduction amount appears on your pay statement. In addition, cost information for all the available options is provided in your initial enrollment package and in the enrollment material distributed each year during open enrollment.

Your contributions for Supplemental Life Insurance, Dependent Life Insurance and Optional AD&D Insurance coverage are deducted from your pay on an after-tax basis. This means that any benefits payable under the Plans will not be taxable to you.

How Your Annual Earnings Determine Your Coverage

For most coverage options, your "annual earnings" are used to determine your Plan coverage. Your annual earnings are the gross amount of money paid to you for performing your job, but not including most bonuses, overtime pay, earnings for more than 40 hours per week or other special compensation. If you participate in the Management Incentive Program, your targeted bonus amount is included in your "annual earnings."

When coverage is described as a multiple of your annual earnings, the Plan multiplies your annual earnings and rounds up to the next highest multiple of \$1,000 to determine your coverage.

Diana's annual earnings are \$31,125. She chooses Option 3 for Basic Life Insurance, with coverage of two times her annual earnings. Her coverage amount is \$63,000, calculated by multiplying her annual earnings by two (\$62,250) and rounding to the next highest \$1,000.

How Life and AD&D Insurance Benefits Are Paid

The Plan pays benefits to the beneficiary named for each option. You may change your beneficiary at any time unless you have assigned your benefits.

Naming a Beneficiary

When you enroll, you submit a beneficiary designation form to your HR Department. Since Basic Life Insurance coverage is automatic, it's important to submit this form even if you do not elect any Supplemental, Dependent or Optional coverage. You may choose one or more individuals, your estate, almost any organization or a trust as your beneficiary. Your beneficiary designation takes effect on the date the properly completed form is received.

You may elect a different beneficiary for each coverage option. *You* are automatically the beneficiary for any Dependent Life Insurance coverage you elect under the Plan.

If you name more than one beneficiary, be sure to indicate the share payable to each one. If you do not indicate this, your beneficiaries will share equally.

If none of your beneficiaries are living when you die, or no beneficiaries are named, death benefits are paid in the following order:

- Your surviving spouse;
- Your surviving child(ren) in equal shares;
- Your surviving parent(s) in equal shares;
- Your surviving sibling(s) in equal shares; or
- Your estate.

Different rules apply if you assign your benefits (see "Benefits Can Be Assigned").

Special rules may apply if your elected beneficiary is under age 18. Please contact your HR Department for more information regarding these rules.

Changing Your Beneficiary

You may change your beneficiary at any time unless you have assigned your benefits (see "Benefits Can Be Assigned"). To change your beneficiary, get a beneficiary change form from your HR Department, complete the form and return it to that Department. Once the form is received, the change is effective as of the date you signed it.

Benefits Can Be Assigned

You may assign your Basic Life Insurance, Optional Life Insurance, Dependent Life Insurance and Optional AD&D Insurance as an irrevocable gift to someone else if the Claims Administrator consents. You may name that person as the owner of your insurance, even though it is your life that is insured. By definition, an irrevocable gift is permanent and cannot be changed or withdrawn once it is made.

If you make an assignment, you give up all present and future rights to the insurance. You cannot revoke the assignment at a later date. The person to whom you assign your insurance has the right to name beneficiaries, to change the level of coverage or to exercise any other privileges under the insurance that would otherwise have been available to you.

Because of the various legal and tax implications involved, you may wish to consult with a lawyer and a tax advisor before making an assignment. If you wish to assign your benefits, call the Corporate Benefits Line at 1-800-997-3247.

A Quick Look at the Options

Here are the options for each type of coverage offered by the Plan.

Basic Life Insurance - For eligible associates, paid for by the Company

- \$10,000;
- \$50,000; or
- 2 times annual earnings, to a maximum of \$800,000.

Optional Life Insurance - For eligible associates, paid for by the associate

- 1 times annual earnings;
- 2 times annual earnings;
- 3 times annual earnings;
- 4 times annual earnings; or
- 5 times annual earnings.

Maximum Optional Life Insurance coverage is \$800,000. Coverage options for 3, 4, or 5 times annual earnings require evidence of insurability.

Optional AD&D Insurance — For eligible associates, paid for by the associate

- 1 times annual earnings;
- 2 times annual earnings;
- 3 times annual earnings;
- 4 times annual earnings; or
- 5 times annual earnings.

Maximum Optional AD&D Insurance coverage is \$800,000.

Dependent Life Insurance - For eligible spouse, paid for by the associate

- \$5,000; or
- \$10,000.

Dependent Life Insurance - For eligible children, paid for by the associate

- \$2,500 (\$1,000 from age 7 days through 11 months); or
- \$5,000 (\$2,000 from age 7 days through 11 months).

Basic Life Insurance

Basic Life Insurance is provided at no cost. The Company pays all premiums.

Basic Life Insurance Coverage Options

You may choose one of the following Basic Life Insurance coverage options:

- Option 1 - a death benefit of \$10,000;
- Option 2 - a death benefit of \$50,000; or
- Option 3 - a death benefit based on two times your annual earnings (described in the section "How Your Annual Earnings Determine Your Coverage").

In most cases Basic Option 3 offers a higher death benefit than Option 1 or 2. Therefore, the premiums paid by the Company for Option 3 are usually higher than those required for Option 1 or 2. **If you elect either Option 1 or 2, you will receive in your paycheck an amount equal to the difference in premium between Option 3 and the Basic Option you select (Option 1 or 2).**

When Evidence of Insurability Is Required

You do not need to provide EOI when your Basic Life Insurance coverage begins. If you apply for an increase in your coverage option — such as moving from Option 1 to Option 2 or 3 — you must provide EOI with your application. See the section "Evidence of Insurability for Life Insurance" for details.

EOI is not required when an increase in your annual earnings increases your Basic Life Insurance coverage under Option 3.

Limits on Coverage

The Plan has two limits on your Basic Life Insurance coverage.

Maximum Dollar Limit

The amount of your Basic Life Insurance coverage under the Plan cannot exceed \$800,000.

Reductions at Age 65

The amount of your Basic Life Insurance coverage reduces by 35% when you reach 65 years of age. This reduction takes place on the January 1st that occurs on or after your 65th birthday.

Imputed Income

If the amount of your Basic Life Insurance coverage (which is paid by the Company) exceeds \$50,000, it is subject to the IRS imputed income reporting requirement. The IRS requires that the Company report the value of any Company-paid life insurance coverage over \$50,000 on your W-2 as earnings. Imputed income earnings are not subject to federal income tax withholding, but the Company must withhold FICA taxes on them.

Optional Life Insurance

Optional Life Insurance is offered to eligible associates on a voluntary basis. If you choose this coverage, you pay all premiums on an after-tax basis.

Optional Life Insurance Coverage Options

You may select one of the following options, or you may decline coverage.

- Option 1 —a death benefit based on one times your annual earnings (described in the section "How Your Annual Earnings Determine Your Coverage");
- Option 2 — a death benefit based on two times your annual earnings;
- Option 3 — a death benefit based on three times your annual earnings;
- Option 4 — a death benefit based on four times your annual earnings; or
- Option 5 —a death benefit based on five times your annual earnings.

When Evidence of Insurability Is Required

You must provide evidence of insurability for your Optional Life insurance if:

- You elect Optional Life insurance more than 30 days after your initial eligibility date;
- You elect Option 3, 4 or 5 at any time;
- You apply to increase your coverage, such as from Option 1 to 2;
- You drop all or some of your Optional Life insurance coverage and decide to elect coverage again at a later date;
- You previously submitted required evidence of insurability and were denied coverage; or
- Your previous coverage ends due to non-payment of premiums.

See the "Evidence of Insurability for Life Insurance" section for details.

No evidence of insurability is required if your coverage amount increases because your annual earnings have increased.

Limits on Coverage

The Plan has two limits on your Optional Life Insurance coverage.

Maximum Coverage Dollar Amount

Your Optional Life Insurance coverage under the Plan is limited to \$800,000.

Reductions at Age 65

The amount of your Optional Life Insurance coverage reduces by 35% when you reach 65 years of age. This reduction takes place on the January 1st that occurs on or after your 65th birthday.

Dependent Life Insurance

Dependent Life Insurance is offered to eligible associates on a voluntary basis. If you choose this coverage, you pay all premiums on an after-tax basis.

Dependent Life Insurance Coverage Options

You may select one option for your spouse and/or one option for your children, or you may decline either or both coverages.

Dependent Life Insurance for Your Spouse

- Option 1 — a death benefit of \$5,000; or
- Option 2 — a death benefit of \$10,000.

Dependent Life Insurance for Your Children

The option you choose applies to all your eligible dependent children. The cost you pay covers all your eligible children.

Option 3 — a death benefit of \$2,500; or
Option 4 — a death benefit of \$5,000.

Limits on Coverage

The Plan limits Dependent Life Insurance coverage for children between the ages of seven days to 12 months of age as follows:

Option 3 — death benefit is limited to \$1,000; and
Option 4 — death benefit is limited to \$2,000.

When Evidence of Insurability Is Required

You must provide evidence of insurability for Dependent Life Insurance for your spouse only if:

- You elect Dependent Life Insurance more than 30 days after your spouse's initial eligibility date (such as when you first become eligible for the Plan, or when you marry);
- You apply to increase Dependent Life Insurance coverage for your spouse, such as from Option 1 to 2;
- You drop all or some of your Dependent Life Insurance coverage for your spouse and decide to elect coverage again at a later date;
- You previously submitted required evidence of insurability and your spouse was denied coverage; or
- Your spouse's previous coverage ends due to non-payment of premiums.

No evidence of insurability is required for Dependent Life Insurance for your children.

See the section "Evidence of Insurability for Life Insurance" for details.

Optional AD&D Insurance

Optional AD&D Insurance is offered to eligible associates on a voluntary basis. If you choose this coverage, you pay all premiums on an after-tax basis.

Optional AD&D Insurance Coverage Options

You may choose from one of the options, or you may decline coverage.

- Option 1 —a coverage amount based on one times your annual earnings (described in the section "How Your Annual Earnings Determine Your Coverage");
- Option 2 — a coverage amount based on two times your annual earnings;
- Option 3 — a coverage amount based on three times your annual earnings;
- Option 4 — a coverage amount based on four times your annual earnings; or
- Option 5 —a coverage amount based on five times your annual earnings.

Evidence of insurability is not required for Optional AD&D Insurance.

How Optional AD&D Insurance Pays Benefits

If you elect Optional AD&D Insurance, the Plan pays a benefit only when a qualifying accident is the sole cause of a "covered loss." This chart shows the Plan's covered losses for AD&D Insurance and the benefit paid for each. Unless shown differently in the chart, you must suffer the covered loss within 90 days after your qualifying accident.

Covered Loss	AD&D Benefit	Notes/Definitions
Life	100% of AD&D coverage amount to your beneficiary(ies)	
Both hands or both feet	100% of AD&D coverage amount to you	Actual severance of foot at or above ankle. Actual severance at or above the wrist, or of thumb and finger at or above the knuckles joining each to hand (metacarpophalangeal joint).
One hand and one foot	100% of AD&D coverage amount to you	
One hand or one foot	50% of AD&D coverage amount to you	
Thumb and index finger of same hand	25% of AD&D coverage amount to you	
Sight of both eyes	100% of AD&D coverage amount to you	Total and permanent loss of sight in one or both eyes.
Sight of one eye	50% of AD&D coverage amount to you	
Sight of one eye and: One hand; or One foot	100% of AD&D coverage amount to you	As defined above.

Continued...

Covered Loss	AD&D Benefit	Notes/Definitions
Speech and hearing	100% of AD&D coverage amount to you	Total and permanent loss of speech. Total and permanent loss of hearing in both ears.
Speech	50% of AD&D coverage amount to you	
Hearing	50% of AD&D coverage amount to you	
Quadriplegia	100% of AD&D coverage amount to you	Complete and irreversible paralysis of both upper and lower limbs within 365 days of accident.
Paraplegia	75% of AD&D coverage amount to you	Complete and irreversible paralysis of both lower limbs within 365 days of accident.
Hemiplegia	50% of AD&D coverage amount to you	Complete and irreversible paralysis of upper and lower limbs on one side of the body within 365 days of accident.

Additional Death Benefits

The Plan offers these additional benefits when a covered loss results in your death.

Seat Belt Benefit

If a covered loss results in your death while you are in a four-wheel vehicle and you are properly wearing a factory-installed seat belt, the Plan pays its seat belt benefit in addition to its death benefit. The seat belt benefit is the lesser of:

- 10% of your AD&D coverage amount; or
- \$10,000.

Verification of the use of the seat belt must be part of the official report of the accident, or it must be certified in writing by the investigating officer.

Supplemental Restraint System Benefit

If a covered loss results in your death while you are in a four-wheel vehicle and the vehicle's factory-installed supplemental restraint system (such as an air bag) deploys, the Plan pays its supplemental restraint system benefit in addition to its death benefit. The supplemental restraint system benefit is the lesser of:

- 10% of your AD&D coverage amount; or
- \$10,000.

Verification of the deployment of the supplemental restraint system must be part of the official report of the accident, or it must be certified in writing by the investigating officer.

Limits on Coverage and Benefits

The Plan has two limits on your Optional AD&D Insurance coverage, and one limit on your Optional AD&D Insurance benefits.

Maximum Coverage Dollar Amount

The amount of your Optional AD&D Insurance coverage under the Plan cannot exceed \$800,000.

Reductions at Age 65

The amount of your Optional AD&D Insurance coverage reduces by 35% when you reach 65 years of age. This reduction takes place on the January 1st that occurs on or after your 65th birthday.

Benefit Limits for Multiple Covered Losses

If a single accident results in more than one covered loss, your total benefit from the Plan is limited to 100% of your AD&D coverage amount.

What Is Not Covered

There are some losses that are not covered under Optional AD&D insurance. Specifically, no benefits are paid for accidental death or losses caused by:

- Suicide or attempted suicide while sane or insane;
- Injuring or attempting to injure yourself on purpose;
- Sickness (regardless of whether the loss is a direct or indirect result of the sickness);
- Medical treatment of an illness or surgical procedure;
- An infection (unless it's a pyogenic infection caused by an external visible wound as a result of an accident or a bacterial infection caused by accidental ingestion of a contaminated substance);
- War or any act of war ("war" means declared or undeclared war and includes resistance to armed aggression);
- An accident that occurs while on full time active military duty for more than 30 days in any armed forces (except for Reserve or National Guard active duty for training);
- Travel or flight in any vehicle used for aerial navigation (includes getting in, out, on or off any such vehicle) if you are:
 - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - Performing as a pilot or a crew member of any aircraft, other than an aircraft owned leased or operated by the Company; or
 - Riding as a passenger in an aircraft owned, leased, or operated by the Company.
- Your commission or attempted commission of a felony;

- Being legally intoxicated or under the influence of any narcotic (unless administered on the advice of a doctor); or
- Participation in any of the following hazardous sports: scuba diving, bungee jumping, skydiving, parachuting, hang gliding or ballooning.

The Claims Administrator determines whether benefits will be paid.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

If You Are on an Approved Leave of Absence or Approved Disability Leave

Continuing Coverage During Your Leave

If you are on an approved leave of absence (including a leave under the Family and Medical Leave Act) or approved disability leave, your Plan coverage may continue.

- If you are on an approved, paid leave (you receive compensation directly from the Company), your Basic Life Insurance (Company-paid) will continue during your leave. Your Optional and Dependent Life Insurance and Optional AD&D Insurance will also continue, and premiums for your Plan coverage will continue to be deducted from your paycheck.
- If you are on an approved, unpaid medical leave (you receive either no compensation or you receive compensation from a source other than the Company, such as from a group plan or individual disability insurance policy), your Basic Life Insurance (Company-paid) will continue during your leave, so long as you remain an active associate of the Company. Your Optional and Dependent Life Insurance and Optional AD&D Insurance will also continue during your leave, so long as you remain an active associate of the Company and you pay premiums for your Plan coverage. The HR Department will send you a letter detailing the payment arrangements.
- If you are on an approved, unpaid personal leave (you receive no compensation from the Company), your Basic Life Insurance coverage ends 30 days after your unpaid personal leave begins. Your Optional and Dependent Life Insurance and Optional AD&D Insurance will also continue during your leave, so long as you remain an active associate of the Company and you pay the required premiums. The HR Department will send you a letter detailing the payment arrangements.

If you choose to continue Plan coverage during your leave, but you terminate your employment or fail to return from leave and your employment is terminated, your coverage ends on the date on which your employment terminates or on the date your premiums ended, whichever is earlier. You may be able to convert all or part of your Basic, Optional and/or Dependent Life Insurance to an individual policy when these coverages end. (See "Converting Coverage to an Individual Policy.")

Approved Leave of Absence Under Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of life and AD&D insurance coverage and re-employment in regard to your military leave of absence. These requirements apply to coverage under the Plan for you and your eligible dependents.

Continuation of Coverage — If you are on an approved military leave of absence, your coverage under the Plan may continue, as long as you make any required premium contributions. For leaves of 31 days or more, you may continue coverage for yourself and your

eligible dependent. You continue coverage by paying the required premiums to the Company, until the earliest of the following:

- 24 months from the last day of employment with the Company;
- The day after you fail to return to work; and
- The date the Plan ends.

Reinstatement of Coverage — If your coverage ends during the leave of absence because you do not elect USERRA continuation coverage and you are re-employed by the Company, coverage for you and your eligible dependents under the Plan may be reinstated if:

- You gave the Company advance written or verbal notice of your military service leave; and
- The duration of all military leaves while you are employed with the Company does not exceed two years.

If You Terminate Your Employment

Your coverage under the Plan ends on the day your employment terminates, whether or not your termination was due to your failure to return from a leave of absence. When coverage ends, you may be eligible to convert all or part of your Basic, Optional and/or Dependent Life Insurance to an individual policy when these coverages end, (See "Converting Coverage to an Individual Policy.")

If You Gain a New Dependent

If you gain a new dependent (for example, through marriage, birth or adoption), you may enroll him or her for Dependent Life coverage if you do so within 30 days of the date he or she becomes your eligible dependent. You must provide the Company with any documentation that may be required to verify the person's status as your dependent.

If a Dependent Loses Eligibility

If a dependent no longer meets the eligibility requirements, he or she may be able to elect portability or convert all or part of his or her Dependent Life Insurance to an individual policy when that coverage ends. (See "When Coverage Ends" for details.)

If You Die

If you die, coverage for your dependents ends. However, your eligible covered dependents may be able to elect portability or convert all or part of their Dependent Life Insurance to an individual policy when that coverage ends. (See "When Coverage Ends" for details.)

If You Become Terminally Ill

If you are diagnosed as being terminally ill with a life expectancy of six months or less, **the accelerated payment option** allows you to receive a portion of your Basic and Optional Life Insurance benefit from the Plan before you die. You may request any amount up to the lower of \$100,000 or 50% of your combined Basic and Optional Life Insurance benefit. You may use this money in any way you wish.

The accelerated payment option is not available for Dependent Life Insurance or Optional AD&D Insurance.

The accelerated payment option you receive reduces both the amount of death benefit payable to your beneficiary and the amount of coverage available to you for conversion or portability. The accelerated payment benefit you receive may be taxable to you; please consult a professional tax advisor before you apply for this option.

Here are some guidelines that may affect your eligibility or decision to apply for this benefit:

- You are not eligible for the accelerated payment option if you previously assigned your life insurance coverage (see "Benefits Can Be Assigned").
- You must submit satisfactory proof to the insurance company that you are terminally ill, including certification by a doctor.
- If your Basic and Optional Life Insurance coverage is scheduled to be reduced within six months of the date your request is received, your accelerated payment option is limited to 50% of the reduced coverage amount.
- Accelerated benefit payments may affect your eligibility for benefits under state and federal law.

Claims

You or your beneficiary must file a claim to apply for benefits or to request the accelerated payment option.

Filing a Claim For Life Insurance or AD&D Insurance Benefits

To report a death or other covered loss, you (or your beneficiary, if you die) should call the Corporate Benefits Line at 1-800-997-3247. You (or your beneficiary) will be sent all the necessary claim forms to complete.

To file a claim:

- Call to report the death or loss.
- Follow the instructions on the claim form carefully and answer all questions completely.
- If you are filing a claim for death benefits, attach the death certificate.
- Submit the required paperwork as directed on the forms.
- In addition, the following applies for Optional AD&D Insurance claims:
 - While a claim for accidental dismemberment benefits is pending, the Claims Administrator has the right to appoint a physician to examine you as often as it may reasonably require.
 - For accidental death claims, the Claims Administrator also has the right to have an autopsy made, where it is not forbidden by law.

The Claims Administrator evaluates all claims to determine if any benefits will be paid. If the claim is approved, payment will be made. If any benefits are denied, a written explanation will be sent. If there is a question about a claim payment, you or your beneficiary(ies) may request an explanation from the Claims Administrator.

If a claim is denied, you or your beneficiary(ies) may appeal the decision (see "Claim Denial and Appeal Procedures").

Filing a Claim for the Accelerated Payment Option (Basic and Optional Life Insurance Only)

To request the accelerated payment option, call the Corporate Benefits Line at 1-800-997-3247 for the necessary forms to complete.

AD&D Insurance Filing Deadline

You should submit claims for AD&D Insurance benefits within 90 days after the date of the loss. If it is not reasonably possible to provide proof within this time frame, an extension may be granted if you (or your beneficiary) can prove you furnished the proof as soon as reasonably possible.

Other Important Claims Information

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Claim Determination Procedures

The Claims Administrator - Prudential - will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- A description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:

- The specific reason(s) for the adverse determination;
- References to the specific Plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
- A description of Prudential's review procedures and applicable time limits;
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential will make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

When Coverage Ends

This section outlines when coverage ends, and your options for continuing coverage.

When Associate Coverage Ends

Your Basic Life Insurance, Optional Life Insurance and Optional AD&D Insurance end on the earliest date one of the following events occur:

- You stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Perdue Incorporated life insurance benefits or benefit is terminated; or
- You fail to pay any required premiums (not eligible for portability or conversion).

When Dependent Coverage Ends

Dependent Life Insurance ends on the date your own life insurance coverage ends, or it may also end on the earliest date that one of the following events occur:

- Your covered dependent is no longer eligible;
- The Plan is terminated; or
- You fail to pay any required premiums.

Portability

Your Optional Life Insurance, Dependent Life Insurance and Optional AD&D Insurance include a portability provision. This allows you and your covered dependents to continue insurance coverage. You may not elect portability for your Basic Life Insurance.

You must elect portability for your Optional Life Insurance in order for your covered spouse and/or children to elect portability for their Dependent Life Insurance. However, your dependents can elect portability if their coverage ends due to divorce or your death.

Generally, you and your covered dependents can elect portability if:

- You and your spouse are under age 80;
- Your covered dependent children are under age 26; and
- You are actively at work on the date before employment ends (exception made if you are disabled associates).

Generally, you and your covered dependents cannot elect portability if:

- Contributions are not up to date;
- The dependent is confined for medical care or treatment, either at home or elsewhere, on the date your life insurance coverage ends;
- The Plan ends and is replaced by another group plan within 31 days.

These limits apply to the amount of Optional Life Insurance and Optional AD&D Insurance available for portability:

- Minimum: \$20,000;
- Maximum: The lesser of:
 - Five times your annual earnings; or
 - \$1 million.

Converting Coverage to an Individual Policy

You may convert all or part of your Basic, Optional and/or Dependent Life Insurance to an individual policy when that coverage ends. You may not convert your Optional AD&D Insurance. Conversion is not available if:

- Contributions are not up to date;
- The Basic, Optional and/or Dependent Life Insurance is terminated for all members in your employment class, and you have maintained this coverage for less than five years at termination.

To convert your eligible coverages, you must request the conversion within a specific period, which is the later of:

- 31 days after your coverage ends; or
- 15 days after you receive written notice of your right to choose conversion (but no later than 92 days after your coverage ends).

No evidence of insurability is required during this period. If an eligible person dies during this conversion period, the beneficiary will receive the full amount of the life insurance available for conversion.

The individual policy will be one customarily issued by the Claims Administrator for conversions. If you are interested in converting your insurance, call the Corporate Benefits Line at 1-800-997-3247.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants will be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should

happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Plan is fully-insured through an insurance contract with The Prudential Insurance Company of America ("Prudential"). The Company pays the costs associated with providing you with Basic Life Insurance. You pay the full cost for any Optional Life Insurance, Dependent Life Insurance or Optional AD&D Insurance you elect. Any costs you pay for coverage go toward the total premium paid by the Company to Prudential.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an "at-will employee," either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the Plan document, including the group insurance contract, that determines your rights and the rights of your dependents under the Plan. If there is a discrepancy between this summary plan description and the Plan document, including the group insurance contract, the Plan document, including the group insurance contract, will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan, the group insurance contract, or other documents maintained in conjunction with the Plan.

Benefits Provided by Group Contract

The life insurance and AD&D insurance benefits in the Plan are governed by a group insurance contract, underwritten by The Prudential Insurance Company of America (Prudential), and provide insured benefits under Plan. Prudential as Claims Administrator has the sole discretion to interpret the terms of the group insurance contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator will not be overturned unless arbitrary and capricious.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the Plan document, including the group insurance contract). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan will be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Life and AD&D Insurance Plan Identification

Plan Name	The official Plan name is the Perdue Farms Inc. Life and Accidental Death and Dismemberment Insurance Plan.
Plan Sponsor	The Plan Sponsor is Perdue Incorporated.
Type of Administration	The life and AD&D insurance benefits under the Plan are administered by an insurance contract with The Prudential Insurance Company of America.
Plan Administrator	The Plan Administrator is: The Perdue Benefits Committee Perdue Farms Inc. 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Insurer/Claims Administrator	The insurer/Claims Administrator is: The Prudential Insurance Company of America 80 Livingston Avenue Roseland, NJ 07068 The group insurance contract number is G-37560.
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Farms Inc. Life and Accidental Death & Dismemberment Insurance Plan is: Perdue IFarms Inc. 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.
Plan Records and Plan Year	The Perdue Farms Inc. Life and Accidental Death and Dismemberment Insurance Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Farms Inc. Life and Accidental Death and Dismemberment Insurance Plan, which is a component of the Perdue Incorporated Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 502.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

THE PERDUE LONG-TERM DISABILITY INSURANCE PLAN SUMMARY PLAN DESCRIPTION

**For non-union associates in
Benefit Group 1 – Salaried/Exempt**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de seguro por discapacidad a largo plazo de Perdue Incorporated. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Revised January 1, 2010

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2010, to eligible full-time non-union associates under the Perdue Long-Term Disability (LTD) Plan (referred to here simply as “the Plan”). This SPD summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior LTD Plan SPDs for associates in Benefit Group 1.

There are separate SPDs for associates in Benefit Groups 1-A, 2 and 3. If you are in one of these Benefit Groups, contact your local Human Resources (HR) Department for a copy of the SPD that applies to you. Associates in Benefit Group 4 are not eligible for coverage.

More detailed information is provided in the official plan document and group contracts, copies of which are available upon request. If there is a difference between how the SPD and the plan document and group contracts describe the eligibility rules and the benefits being provided under the Plan, the plan documents and group contracts will control and govern the operation of the Plan.

Perdue Incorporated (“the Company”) has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and group contract).

If you have questions regarding your benefits, please call the Corporate Benefits Line at 1-800-997-3247. Participation in the Plan is neither an offer nor a guarantee of future employment.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 37560.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Introduction

The LTD Plan can provide you with a percentage of your monthly earnings during a covered disability.

There are three options under the Plan. If you are an eligible associate, you may choose one of the following options.

- **Option 1** replaces up to 50% of your monthly earnings;
- **Option 2** replaces up to 60% of your monthly earnings; and
- **Option 3** replaces up to 66.67% of your monthly earnings.

If you do not elect a coverage option by the date specified in your enrollment materials, and you meet the Plan's eligibility requirements, you will automatically be enrolled in Option 2.

Eligibility

This section outlines the Plan's rules of eligibility for associates to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are a Salaried/Exempt associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In Benefit Group 1: Salaried/Exempt

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In one of these Benefit Groups:
 - Benefit Group 1-A
 - Benefit Group 2: Administrative/Technician – Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor – Hourly/Non-exempt, Piece Rate
 - Benefit Group 4: General Labor – Hourly/Non-exempt, Piece Rate
- In a job class covered by a collective bargaining agreement;
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Protection Against Use of Genetic Information

The Plan will not deny, limit or cancel Plan coverage for you based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please call the Corporate Benefits Line at 1-800-997-3247. The Company is the "Claims Fiduciary" for eligibility for the Plan.

Enrollment and Cost

If you want Plan coverage, you must enroll. If you are eligible and do not enroll, the Company will automatically enroll you in Option 2.

The Company pays the cost of coverage under Options 1 and 2, and you and the Company share the cost of Option 3. Amounts you pay for coverage come from your pay on a before-tax basis. The cost of each coverage category is indicated on your personalized enrollment form.

Each year during open enrollment, you may change your elections under the Plan. This means any coverage election you make must remain in effect for up to one year, unless you experience a qualified status change permitting an election change under this Plan or the Premium Conversion Plan. Some change requests require you to provide evidence of insurability.

Newly Hired Associates

The following sections outline the steps required to enroll in the Plan and the dates when your coverage under the Plan begins if you are a newly hired associates.

When and How to Enroll

When you start working for the Company, you will be provided with an enrollment package. The package will include information about your coverage options, their costs, enrollment forms and instructions and the date by which you must make your elections.

You must complete, sign and return your enrollment forms (including any supporting documentation) to your HR Department by the dates outlined in your enrollment materials in order to be covered under the option you elect.

When Your Coverage Begins

Coverage begins on the first day of the calendar month on or after your first day of employment with the Company, if you return your enrollment forms by the date specified in your enrollment materials and are "actively at work" on the date coverage is scheduled to begin. If you do not return your enrollment form by the deadline, you will be automatically enrolled in Option 2.

What Does "Actively at Work" Mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer's place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

Current Associates – Change Existing Coverage

If you want to change your coverage, you may make changes only:

- During an open enrollment period in which Plan coverage is offered; *or*
- After a qualified status change permitting an election change under this Plan.

An application to increase Plan coverage from Option 1 to Option 3 requires you to provide “evidence of insurability” as described in the section “Evidence of Insurability.” When the increase is approved, you must be actively at work in order for that increase to take effect.

Open Enrollment Changes

During the annual open enrollment period, your enrollment package will include information about the coverage options available to you under the Plan. At that time you will have an opportunity to select the coverage that best meets your needs for the coming year.

If you meet the eligibility rules, you may increase or decrease coverage during this open enrollment period. In order to change your coverage during the annual open enrollment period, you must complete, sign and return your enrollment forms (including any supporting documentation or proof required) to your HR Department by the dates outlined in your open enrollment materials. Plan elections or changes you make during the annual open enrollment period take effect on the first day of the following calendar year. If you do not elect to make any changes, your current coverage option will continue.

If you apply to increase your Plan coverage, you must provide “evidence of insurability,” as described in the next section. When the increase is approved, you must be actively at work in order for the increase to take effect.

Evidence of Insurability

If evidence of insurability (EOI) is required, you must provide health and financial information to the Claims Administrator. The Claims Administrator reviews the information to determine whether your application will be approved. In some cases, providing evidence of insurability may require a physical examination by a doctor.

Qualified Status Changes Permitting an Election Change

You may change your coverage during the year if you have a qualified status change that permits you to change your election under the Plan.

A qualified status change is defined as a change in status that affects your coverage, including the events listed in the following chart:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death.
Work Schedule	A reduction or increase in hours of employment by you, including a switch between part-time and full-time.

Any change you make must be consistent with the actual event. In order to make a change, you must complete, sign and return an enrollment form to the HR Department within 30 days of the date of the qualifying family status change (for example, dependent birth date, date of marriage). You must provide proof of the qualifying event (for example, a marriage or dependent birth certificate).

If you change your coverage within 30 days of a qualified family status change, your change is effective as of the date the family status change occurs, or when your evidence of insurability is accepted by the Claims Administrator (if applicable). If you miss the deadline, you must wait until the next open enrollment period in which Plan coverage is offered to request a change.

Your Cost

The Company pays the full cost to provide you with coverage under Option 1 **or** Option 2. If you do not elect an option, you are automatically enrolled in Option 2.

If you elect Option 1 or Option 3, here is the effect on your cost :

- If you elect Option 1, you will receive a nominal taxable earnings credit in your pay statement. Information about the amount of this credit is provided in your initial enrollment form.
- If you elect Option 3, you and the Company share the cost. Your payroll deduction amount appears on your pay statement. In addition, cost information is provided on your initial enrollment form. Your share of the cost for Option 3 is deducted from your pay on a before-tax basis.

Regardless of which option you choose, any benefits you receive from the Plan will be taxable to you.

A Quick Look at the Options

Here are the coverage options offered by the Plan.

Timing	Definition of Disability	LTD Benefit
First 180 days	You are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury	None – this is your “elimination period”
Next 24 months		Percentage of your monthly earnings shown below, to a maximum of \$10,000 <ul style="list-style-type: none">• Option 1: 50%• Option 2: 60%• Option 3: 66.67%
After 24 months of LTD benefits	You are unable to perform the duties of any gainful occupation for which you are reasonably qualified by education, training and experience	Percentage of your monthly earnings shown below, to a maximum of \$10,000 <ul style="list-style-type: none">• Option 1: 50%• Option 2: 60%• Option 3: 66.67%

Your Long-Term Disability Coverage

This section explains some of the basics about your coverage under the Plan.

Amount of Coverage

Each of the Plan's coverage options, when combined with income from certain other sources, can provide you with up to your coverage option's percentage of your monthly earnings during a covered disability, subject to the Plan's maximum.

Keep in mind that LTD benefits are paid in combination with certain other sources of disability income. This means the percentage shown in the chart above for each option is actually the total amount of disability income you can receive when the Plan benefit is combined with benefits from other sources. For more information, see "How Benefits Are Combined...a Few Examples" and "Other Sources of Disability Income."

How Your Monthly Earnings Determine Your Coverage

Your "monthly earnings" are used to determine your Plan coverage. Your monthly earnings are the gross amount of money paid to you for performing your job, but not including commissions, bonuses, overtime pay or other special compensation.

If Your Earnings Increase

If your monthly earnings increase, here is what happens:

- If you are actively at work or on an approved non-medical leave of absence on the date your monthly earnings increase, your coverage increases on the same date. This means if you become disabled on or after the date of the increase, any benefit you may be entitled to receive will be based on your higher monthly earnings.
- If you are absent due to sickness or injury on the date your monthly earnings increase, your coverage increase will take effect on the date you return to active work.

If Your Earnings Decrease

If your monthly earnings decrease, here is what happens:

- The amount of your coverage decreases immediately regardless of your employment status. This means if you become disabled on or after the date of the decrease, any benefit you may be entitled to receive will be based on your lower monthly earnings.
- If you are currently receiving or entitled to receive a benefit from the Plan, the amount of that benefit will not be affected by your decreased earnings. This means the amount of your benefit will continue to be based on your monthly earnings in effect when your disability began.

Maximum Benefit

The maximum monthly benefit the Plan pays is \$10,000.

Minimum Benefit

The minimum monthly benefit the Plan pays is the greater of:

- \$100; or
- 10% of your gross disability payment.

Taxes on Plan Benefits

Because the Company pays the full cost for Option 1 and Option 2, any LTD benefits you receive from the Plan under one of these options will be taxable.

If you elect Option 3, you and the Company share the cost for that coverage. Since you pay your share of the cost on a before-tax basis, any LTD benefits you receive under this option are also taxable.

When Your Coverage Ends

Your coverage ends on the earliest date one of the following events occur:

- You stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Plan is terminated; or
- You fail to pay any required contributions.

Note: If you are entitled to receive benefits for a disability which occurred before your coverage ends, LTD benefits for that disability will continue, so long as you remain disabled under the terms of the Plan.

How You Qualify for LTD Benefits

To receive benefits under the Perdue Incorporated LTD Plan, you do not have to be hospitalized or confined to a home, but you must be considered disabled under the Plan. This may differ from being considered disabled for purposes of any Pension, Short Term Disability, Workers' Compensation, Social Security or other benefits you might be entitled to. When you are disabled under the Plan, your benefits begin after you meet the 180-day elimination period.

The Plan's requirement for disability changes over time.

- During the 180-day elimination period and the next 24 months, to be considered disabled under the Plan you must be unable to perform the material and substantial duties of your regular occupation, due to your sickness or injury.
- After this period, to be considered disabled under the Plan you must be unable to perform the duties of *any* gainful occupation for which you are reasonably qualified by education, training or experience, due to your sickness or injury.

At all times during your disability, to receive Plan benefits you must:

- Be under the regular care of a doctor and following the recommended care and course of treatment;
- Submit proof of your continuing disability to the Claims Administrator from time to time; and
- Earn no more than 80% of your indexed monthly earnings.

Failure to meet these requirements on a timely basis will cause your benefits to end.

The Claims Administrator will determine the extent of your disability based on medical evidence and reserves the right to have a physician of its choice examine you.

Important Terms to Know

Elimination Period – The 180-day period beginning on the first day of your disability. If your disability stops for 30 consecutive days or less during your elimination period, your disability is considered continuous, but the days you are not disabled will not count toward your 180-day elimination period. But if your disability stops for more than 30 days, you must meet a new elimination period before your Plan benefits may begin.

Material and Substantial Duties – These are the duties that are normally required for the performance of your regular occupation that cannot be reasonably omitted or modified. But if you are required to work on average in excess of 40 hours per week, the Claims Administrator will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Regular Occupation – The occupation you are routinely performing when your disability begins. The Claims Administrator looks at your occupation as it normally is performed nationwide, rather than how it is performed by a specific employer or at a specific location.

Gainful Occupation – An occupation (including self-employment) that is or can be expected to provide you with an income within 12 months of the date you return to work that exceeds:

- *If you are working*, 60% of your “indexed monthly earnings”; or
- *If you are not working*, the income replacement percentage of your coverage option (Option 1, 50%; Option 2, 60%; Option 3, 66.67%).

Indexed Monthly Earnings – Your monthly earnings adjusted on each July 1 by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but they will never decrease. You must be disabled for a full 12 months before July 1 to receive this adjustment. Indexed Monthly Earnings is only used to determine your percentage of lost earnings if you are disabled and working.

When LTD Benefits Begin and End

The Plan’s LTD benefits begin on the day after you complete the 180-day elimination period. As long as you remain disabled under the Plan, your LTD benefits will continue.

For disabilities *other than those related to self-reported symptoms or mental illness*, your LTD benefits end when the first of these events occurs:

- You are able to work in your regular occupation on a part-time basis during the first 24 months of benefit payments from the Plan, but you choose not to do so.
- You are able to work in any gainful occupation on a part-time basis after 24 months of benefit payments from the Plan, but you choose not to do so.
- You are no longer disabled as defined under the Plan.
- You fail to submit proof of your continuing disability.
- Your disability earnings exceed the amount allowable under the Plan.
- You decline to participate in a rehabilitation program that the Claims Administrator considers appropriate for your situation and is approved by an independent doctor.
- You reach the maximum payment period for receiving benefits (described below).
- You die.

For disabilities related to self-reported symptoms or mental illness, see “Limitations Apply to Certain Disabilities.”

Survivor Benefit

If you die while receiving a disability benefit, your eligible survivor may be entitled to receive a one-time payment from the Plan. Your eligible survivor is your surviving spouse. If you have no surviving spouse, your eligible survivors are your children under age 25.

The survivor benefit is paid if, on your date of death:

- Your disability had continued for at least 180 consecutive days; and
- You were receiving, or you were entitled to receive, payments under the Plan.

The amount of the benefit is equal to three monthly gross disability payments and paid in a single payment. If you have no eligible survivors, payment is made to your estate.

Maximum Payment Period

The maximum period of time for which you can receive payments under the Plan is based on your age when your disability begins as shown in the following chart.

Age When Disability Begins	Maximum Period of Time for Which LTD Payments Continue*
Less than age 62	To your Normal Retirement Age **, but not less than 60 months
Age 62 through age 64	60 months
Age 65 through age 68	To age 70 (but not less than 12 months)
Age 69 and over	12 months
* Not if your disability is related to self-reported symptoms or mental illness	
** Normal Retirement Age is your retirement age under the Social Security Act where retirement age depends upon your year of birth	

Important Terms to Know

Part-Time Basis – The ability to work and earn 20% or more of your indexed monthly earnings.

Disability Earnings – The earnings you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

If You Return to Work From a Covered Disability and Are Disabled Again

If you recover from your disability and then become disabled again, your Plan benefits will be affected.

- If you return to work for the Company for fewer than six months and become disabled again due to the same or related causes, it is counted as one continuing disability. You will not need to satisfy another elimination period. This means your Plan benefits can begin immediately with the Claims Administrator's approval.
- If you return to work for the Company for six months or longer and become disabled again due to the same or related causes, it will be treated as a separate disability. This means you will have to satisfy another 180-day elimination period and file a new claim for the Claims Administrator to approve before Plan benefits can begin again.
- If you return to work for the Company and you become disabled again due to a disability that is unrelated to your previous disability, it will be treated as a separate disability. This means you will have to satisfy another 180-day elimination period and file a new claim for the Claims Administrator to approve before Plan benefits can begin again.

Other Sources of Disability Income

The Plan is designed to work with other sources of disability income to provide your total disability income.

How Other Disability Income Affects Your Benefit

When determining your benefit, the Plan looks at your “deductible sources of income” and makes up the difference. In other words, you still may receive up to the percentage of your monthly earnings specified for your option when your benefit is combined with these deductible sources of disability income.

Deductible Sources of Income

Your gross disability payment under the Plan is reduced by payments you receive – or are entitled to receive – from certain sources. You must apply for any benefits you might be entitled to receive from these sources because the Claims Administrator has the right to estimate the amount of those benefits and to reduce your Plan benefit by the estimated amount, even if you do not apply. Deductible sources of income include, but are not limited to:

- Benefits under the United States Social Security Act, Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act (applies to payments for you, your spouse, and your children);
- Workers’ Compensation or any similar benefits;
- Any state disability benefits; and
- Any other group insurance plan (but not an individual disability income policy).

You must send the Claims Administrator a copy of all information received concerning the approval or denial of benefits from any of these sources. If you receive an award, the Claims Administrator may adjust your Plan benefit to account for any overpayment or underpayment of Plan benefits that were paid based on the estimated benefits.

In addition, your gross disability payment under the Plan will be reduced by these amounts:

- Disability benefits you receive from any Perdue pension plan;
- Retirement payments you voluntarily elect to receive from any Perdue pension plan; and
- Retirement payments you receive when you reach normal retirement age under any Perdue pension plan.

If you receive a cost of living increase from any of these sources after you begin receiving benefits from the Plan, your payment from the Plan will not be further reduced.

Important Term to Know

Gross Disability Payment – The benefit amount before any deductible sources of income and disability earnings are subtracted.

How Benefits Are Combined ... A Few Examples

This chart shows you a few examples of how the different coverage options under the Plan may pay benefits and what your total disability income from all sources could be. The examples assume LTD deductible income of 30% from other sources.

If you are covered under ...	and your LTD deductible income from other sources is ...	your coverage option would pay ...	Your total LTD income from all sources would be ...
Option 1 (up to 50% of your monthly earnings)	30% of your monthly earnings	20% of your monthly earnings	50% of your monthly earnings
Option 2 (up to 60% of your monthly earnings)	30% of your monthly earnings	30% of your monthly earnings	60% of your monthly earnings
Option 3 (up to 66.667% of your monthly earnings)	30% of your monthly earnings	36.6667% of your monthly earnings	66.667% of your monthly earnings

Nondeductible Sources of Income

Your gross disability payment under the Plan will not be reduced by payments you receive from sources such as:

- Profit sharing plans, 401(k) plans or thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Military pension and disability income plans;
- Credit disability insurance;
- Franchise disability income plans;
- Another employer's retirement plan;
- Individual Retirement Accounts (IRAs);
- Individual disability income plans;
- No-fault motor vehicle plans; and
- Salary continuation or accumulated sick leave plans.

However, any benefits you may receive from one of these sources may be reduced in order to coordinate with benefits from this Plan.

About Social Security Disability Insurance Benefit (DIB)

In order to receive maximum disability benefits, you will need to apply for a Social Security Disability Insurance Benefit (DIB). As soon as you become disabled, call the Social Security Administration to learn how to apply for a Social Security Disability Insurance Benefit. Social Security Disability Insurance Benefits will affect your benefit from the Plan benefits as follows:

- Your Plan benefits will be reduced by your estimated Social Security Disability Insurance Benefit, even if you are not actually receiving a Social Security Disability Insurance benefit.
- Your plan benefits will be reduced by any Social Security Disability Insurance Benefits that you, your spouse, and your children may be entitled to receive as a result of your disability.
- If your Social Security Disability Insurance Benefit is determined after your Plan benefit begins, your Plan benefit will be recalculated retroactively. If this recalculation results in an overpayment, you must repay it to the Claims Administrator. You may either make direct payments to the Claims Administrator or have your monthly LTD payments reduced until the overpayment is recovered.

If Social Security denies you benefits, the Plan may require you to file an appeal with Social Security. If you have been notified to file an appeal and you have not done so, your monthly Plan benefits may be reduced by the amount of the Social Security Disability Insurance Benefit you could be receiving had your appeal been successful. But if your application for a Social Security Disability Insurance Benefit has been denied, you have filed all available appeals, but all your appeals have been rejected, your Plan benefits will not be reduced.

If you are not eligible for a Social Security Disability Insurance Benefit because you do not have the necessary number of quarters to qualify, your Plan benefits will not be reduced.

Your Plan benefit will be reduced by your Social Security Old Age Retirement Benefit as follows:

- If you begin receiving Reduced Old Age Retirement Benefit payments your Plan will be reduced by your actual benefit payments received; and
- When you reach normal retirement age your Plan will be reduced by the Social Security Old Age Retirement Benefit you receive.

Employment While You Are Disabled

If you are able to find and accept suitable employment while you are disabled, you still may be entitled to LTD benefits for your disability as outlined in this section. The Rehabilitation Service, described in the section “Rehabilitation Benefits,” may also help you return to work.

How Your Employment Affects Your LTD Benefit

If you are working while you are disabled, the ratio of your monthly disability earnings to your indexed monthly earnings determines whether the Plan’s monthly benefits can continue, and how that benefit may be affected.

If your monthly disability earnings are less than 20% of your indexed monthly earnings, your Plan benefit may continue, provided you continue to meet the Plan’s definition of disability.

If your monthly disability earnings are 20% or more of your indexed monthly earnings – and you continue to meet the Plan’s definition of disability during your continued employment – your Plan benefit will be determined as follows:

- During the first 12 months you are working while disabled, your monthly Plan benefit will not be reduced, so long as the sum of your disability earnings and your gross disability payment is less than or equal to 100% of your indexed monthly earnings. If the combined payment is more than 100% of your indexed monthly earnings, the amount over 100% will be subtracted from your monthly payment.
- After you have worked while disabled for 12 months, future payment will be based on the percentage of income you are losing due to your disability.

When LTD Benefits Stop Due to Disability Earnings

Your LTD payments stop while you are working if:

- **During the first 24 months of Plan payments**, your monthly disability earnings exceed 80% of your indexed monthly earnings; or
- **After 24 months of Plan payments**, your monthly disability earnings exceed 60% of your indexed monthly earnings.

Rehabilitation Benefits

The Claims Administrator has a rehabilitation program available. The Claims Administrator analyzes your medical and vocational information to determine if rehabilitation services might help you return to work.

Once the initial review is completed by the Claims Administrator's rehabilitation program specialists working along with your doctor and other appropriate specialists, the Claims Administrator may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by the Claims Administrator's rehabilitation program specialists, you must receive written approval from the Claims Administrator for the program before it begins.

The rehabilitation program may include, but is not limited to, the following services:

- Coordination with the Company to assist you to return to work;
- Evaluation of adaptive equipment to allow you to work;
- Vocational evaluation to determine how your disability may affect your employment options;
- Job placement services;
- Resume preparation;
- Job seeking skills training;
- Retraining for a new occupation; or
- Assistance with relocation that may be part of an approved rehabilitation program.

If at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that the Claims Administrator considers appropriate for your disability and that has been approved by your doctor, your monthly benefits from the Plan will end.

Additional Benefits Payable When You Participate in a Rehabilitation Program

Rehabilitation Program Payment

The Claims Administrator will send you a rehabilitation payment each month, up to the maximum period of rehabilitation payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of rehabilitation payment for any one period of disability is six months.

The monthly rehabilitation payment is equal to 5% of your monthly Plan benefit. If the monthly rehabilitation payment, together with your monthly Plan benefit, exceeds your maximum monthly benefit, your monthly rehabilitation payment will be reduced by the excess amount.

Rehabilitation Daycare Payment

The Claims Administrator will send you a day care payment each month, up to the maximum period of day care payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of day care payment for any one period of disability is six months.

The monthly day care payment is equal to the amount of your eligible day care expenses, up to the maximum monthly day care amount, which is \$500 times the number of eligible children (your children age 12 or under who live with you, including your legally-adopted children [and children placed with you for adoption], stepchildren, and foster children).

Eligible day care expenses are the monthly expenses you incur for the day care of your eligible children that are:

- Charged by a child-care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- Documented by receipts from the child-care provider which include the child-care provider's Social Security number or taxpayer identification number; and
- Specified in the Claims Administrator-approved rehabilitation program as needed in order for you to participate in the program.

Rehabilitation Spouse and Elder Care Payment

The Claims Administrator will send you a spouse and elder care payment each month, up to the maximum period of spouse and elder care payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of spouse and elder care payment for any one period of disability is six months.

The monthly spouse and elder care payment is equal to the amount of your eligible spouse and elder care expenses, up to the maximum monthly spouse and elder care amount, which is \$500 times the number of eligible family members (your spouse, your parents or grandparents, or your spouse's parents or grandparents who live with you) who have a chronic illness or disability.

Eligible spouse and elder care expenses are the monthly expenses you incur for the care of your eligible family members that are:

- Charged by a licensed adult care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- Documented by receipts from the licensed adult care provider which include the provider's Social Security number or taxpayer identification number; and
- Specified in the Claims Administrator-approved rehabilitation program as needed in order for you to participate in the program.

Chronic illness or disability means one in which there is:

- A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days; or
- A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days.

Substantial assistance means:

- The physical assistance of another person without which the family member would not be able to perform an activity of daily living; or
- The constant presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to the family member while the family member is performing an activity of daily living.

Activities of daily living means:

- **Bathing** – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower
- **Continence** – The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)
- **Dressing** – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs
- **Eating** – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously
- **Toileting** – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- **Transferring** – Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either by walking, using a wheelchair or by other means.

Cognitive impairment means a loss or deterioration in intellectual capacity that is:

- Comparable to and includes Alzheimer's disease and similar forms of irreversible dementia; and
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to person, place or time; and deductive or abstract reasoning.

Substantial supervision means:

Continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect the family member from threats to the family member's health or safety.

Limitations and Exclusions

Certain limitations and exclusions apply under the Plan.

Pre-existing Condition Limitation

During the three-month period before your Plan coverage began or increased, if you received medical treatment, consultation, care, or services – including diagnostic measures, or took prescribed medicines, or followed treatment recommendation for any medical condition – that condition is considered to be a pre-existing condition. The Plan does not pay benefits for certain disabilities caused by a pre-existing condition.

Here is how it works.

- If you become disabled due to a pre-existing condition during the first 12 months after your LTD coverage begins, the Plan will not pay any benefits for that disability.
- If you elect a higher coverage option during annual enrollment, and you become disabled due to a pre-existing condition during the first 12 months after the increase becomes effective, the Plan will not pay any increased benefits for that disability.

If you become disabled more than 12 months after your coverage begins or increases, the pre-existing condition limitation will not apply.

*Tyler has a heart condition and regularly takes prescription drugs to control it. His Plan coverage begins when he joins the Company. Because he used prescription drugs **during the three-month period before his Plan coverage began**, Tyler's heart condition is considered a pre-existing condition. If during his first 12 months of coverage Tyler becomes disabled from an illness related to his heart condition, Tyler will not receive a benefit from the Plan.*

*If Tyler becomes disabled due to his heart condition **after he has been covered by the Plan for 12 months**, he will receive the Plan's monthly disability benefit.*

Limitations Apply to Certain Disabilities

Generally, monthly Plan benefits are limited to 24 months for a disability based on self-reported symptoms or due to mental illness. However, benefits may continue beyond 24 months if you are confined to a hospital or institution for treatment of a mental illness at the end of the 24-month period. In this case, benefits may continue until 90 days after your discharge. If you are confined again for at least 14 consecutive days during the 90-day recovery period after your discharge, additional benefits may be available from the Plan.

Conditions for Which the Mental Illness Limitation Does Not Apply

The 24-month limitation for disabilities due to mental illness limitation does not apply to dementia if it is the result of:

- Stroke;
- Trauma;
- Viral infection;
- Alzheimer's disease; or
- Other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Important Terms to Know

Self-Reported Symptoms – a condition which your doctor cannot verify with tests, procedures or clinical examinations generally accepted in the practice of medicine (for example, headache, pain, fatigue, stiffness, ringing in ears, dizziness, numbness or loss of energy)

Mental Illness – a psychiatric or psychological condition regardless of cause, including (but is not limited to) schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, dementia, substance related disorders and/or adjustment disorders or other conditions. These conditions usually are treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment as standardly accepted.

What Is Not Covered

The Plan does not cover disabilities caused or contributed to by:

- Intentionally self-inflicted injuries;
- Your commission of or attempt to commit a felony;
- A pre-existing condition; or
- War, declared or undeclared, or any act of war.

Your loss of an occupational license or certification does not, in itself, constitute disability. In addition, no benefits are paid for any period of disability during which you are incarcerated.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

If You Terminate Your Employment

If you stop working for the Company for any reason, your coverage under the Plan ends on the date your employment terminates. However, if you are entitled to receive benefits for a disability which occurred before your coverage ends, payments for that disability can continue subject to the terms of the Plan.

If You Are Rehired

If you were covered by the Plan on your termination date, and you are rehired by the Company at a later date, you will be treated the same as a new hire who has never worked for the Company. This means that you will have to re-satisfy all of the eligibility provisions.

If You Die

If you die while you are actively employed by the Company, your coverage ends on your last day of active employment.

If you die while receiving a disability benefit, your eligible survivor may be entitled to receive a one-time payment from the Plan as described in the “Survivor Benefit” section.

If You Are on an Approved Leave of Absence

Your continued coverage under the Plan depends upon the type of your approved leave. If you become disabled while you are covered by the Plan, any Plan benefit you may be entitled to receive will be based on your monthly earnings in effect on the date before your leave began.

FMLA Leaves of Absence

If you are on an approved leave of absence under the Family and Medical Leave Act (FMLA), your coverage under Option 1 or Option 2 will remain in effect as long as you remain an active associate of the Company and you remain on an approved FMLA leave of absence. If you elected Option 3, your coverage will remain in effect as long as you remain an active associate of the Company, you remain on an approved FMLA leave of absence, *and* you make your required contribution.

Military Leaves of Absence

If you are on an approved military leave of absence under the Uniformed Services Employment and Re-employment Rights Act (USERRA), your coverage will remain in effect through the end of the month following the month in which your military leave begins, so long as:

- You remain an active associate of the Company; and
- You remain on an approved military leave of absence; and
- If you elected Option 3, you make your required contribution.

Please remember that even though your coverage under the Plan continues during your leave, any disabilities you sustain due to an act of war are not covered by the Plan.

Personal Leaves of Absence

If you are not on a leave of absence under FMLA or USERRA, your leave of absence would fall under the Company's Personal Leave of Absence policy. If you are on an approved personal leave of absence, your Plan coverage continues through the end of the month following the month in which your personal leave of absence begins, provided you remain an active associate of the Company and make any required contribution. For example, if you begin your personal leave on September 2, you would be eligible to maintain your coverage under the Plan until October 31.

Filing Claims

You are encouraged to notify the Claims Administrator of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send the Claims Administrator written proof of your claim no later than 90 days after your 180-day elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

The claim form is available from your HR Department, or you can request a claim form from the Claims Administrator. If you do not receive the form within 15 days of your request, send the Claims Administrator written proof of claim without waiting for the form. You must notify the Claims Administrator immediately when you return to work in any capacity.

You and the Company must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to the claims administrator.

Information Needed as Proof Of Your Claim

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a physician;
- The appropriate documentation of your monthly earnings;
- The date your disability began;
- The cause of your disability;
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

The Claims Administrator may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 30 days of a request by the Claims Administrator.

In some cases, you will be required to give the Claims Administrator authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. The Claims Administrator will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

Claim Determination Procedures

The Claims Administrator – Prudential – will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the

period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- A description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:

- The specific reason(s) for the adverse determination;
- References to the specific Plan provisions on which the determination was based;

- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
- A description of Prudential's review procedures and applicable time limits;
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential will make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants will be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Plan is fully-insured through an insurance contract with The Prudential Insurance Company of America ("Prudential"). The Company pays the costs associated with Option 1 and Option 2. You and the Company share the cost of Option 3. Any costs you pay for coverage go toward the total premium paid by the Company to Prudential.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an "at-will employee," either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the Plan document, including the group insurance contract, that determines your rights and the rights of your dependents under the Plan. If there is a discrepancy between this summary plan description and the Plan document, including the group insurance contract, the Plan document, including the group insurance contract, will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan, the group insurance contract, or other documents maintained in conjunction with the Plan.

Benefits Provided by Group Contract

The disability income insurance benefits in the Plan are governed by a group insurance contract, underwritten by The Prudential Insurance Company of America (Prudential), and provide insured benefits under Plan. Prudential as Claims Administrator has the sole discretion to interpret the terms of the group insurance contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator will not be overturned unless arbitrary and capricious.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the Plan document, including the group insurance contract). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan will be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

LTD Plan Identification

Plan Name	The official Plan name is the Perdue Long-Term Disability Plan.
Plan Sponsor	The Plan Sponsor is Perdue Incorporated.
Type of Administration	The disability benefits under the Plan are administered by an insurance contract with: The Prudential Insurance Company of America
Plan Administrator	The Plan Administrator is: The Perdue Retirement and Employee Benefits Committee Perdue Incorporated 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Insurer/Claims Administrator	The insurer/Claims Administrator is: The Prudential Insurance Company of America. 80 Livingston Avenue Roseland, NJ 07068
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Long-Term Disability Plan is: Perdue Incorporated 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.
Plan Records and Plan Year	The Perdue Long-Term Disability Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Long-Term Disability Plan, which is a component of the Perdue Incorporated Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 503.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

THE PERDUE LONG-TERM DISABILITY INSURANCE PLAN SUMMARY PLAN DESCRIPTION

For associates in these Benefit Groups:

- **2 – Administrative/Technician – Hourly/Non-exempt**
- **3 – Skilled Labor – Hourly/Non-exempt, Piece Rate**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de seguro por discapacidad a largo plazo de Perdue Incorporated. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Revised January 1, 2010

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2010, to eligible full-time hourly non-union associates under the Perdue Long-Term Disability (LTD) Plan (referred to here simply as “the Plan”). This SPD summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior LTD Plan SPDs for associates in Benefit Groups 2 and 3.

There are separate SPDs for associates in Benefit Groups. If you are in Benefit Group 1, contact your local Human Resources (HR) Department for a copy of the SPD that applies to you. Associates in Benefit Group 4 are not eligible for coverage.

More detailed information is provided in the official plan document and group contracts, copies of which are available upon request. If there is a difference between how the SPD and the plan document and group contracts describe the eligibility rules and the benefits being provided under the Plan, the plan documents and group contracts will control and govern the operation of the Plan.

Perdue Incorporated (“the Company”) has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and group contract).

If you have questions regarding your benefits, please call the Corporate Benefits Line at 1-800-997-3247. Participation in the Plan is neither an offer nor a guarantee of future employment.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 37560.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Introduction

The LTD Plan can provide you with a percentage of your monthly earnings during a covered disability.

If you are an eligible associate, you may elect coverage that can replace up to 50% of your monthly earnings.

Eligibility

This section outlines the Plan's rules of eligibility for associates to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are an hourly associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In one of these Benefit Groups:
 - Benefit Group 2: Administrative/Technician – Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor – Hourly/Non-exempt, Piece Rate

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In Benefit Group 1: Salaried/Exempt;
- In Benefit Group 4: General Labor – Hourly/Non-exempt, Piece Rate;
- In a job class covered by a collective bargaining agreement;
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Protection Against Use of Genetic Information

The Plan will not deny, limit or cancel Plan coverage for you based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please call the Corporate Benefits Line at 1-800-997-3247. The Company is the "Claims Fiduciary" for eligibility for the Plan.

Enrollment and Cost

If you want Plan coverage, you must enroll. You pay the cost of coverage through payroll deductions on a before-tax basis. The cost of coverage category is indicated on your personalized enrollment form.

Each year during open enrollment, you may change your election under the Plan. This means any coverage election you make must remain in effect for up to one year, unless you experience a qualified status change permitting an election change under this Plan or the Premium Conversion Plan.

Newly Hired Associates

The following sections outline the steps required to enroll in the Plan and the dates when your coverage under the Plan begins if you are a newly hired associates.

When and How to Enroll

When you start working for the Company, you will be provided with an enrollment package. The package will include information about coverage and its cost, enrollment forms and instructions and the date by which you must make your election.

You must complete, sign and return your enrollment forms (including any supporting documentation) to your HR Department by the dates outlined in your enrollment materials in order to be covered under the option you elect.

When Your Coverage Begins

Coverage begins on the first day of the calendar month on or after the date you complete three months of employment with the Company, if you return your enrollment forms by the date specified in your enrollment materials and are "actively at work" on the date coverage is scheduled to begin. If you do not return your enrollment form by the deadline, you will have to wait until the next annual enrollment period or until you experience a change in family status.

What Does "Actively at Work" Mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer's place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

Current Associates – Change Existing Coverage

If you want to change your coverage, you may make changes only:

- During an open enrollment period in which Plan coverage is offered; *or*
- After a qualified status change permitting an election change under this Plan.

Open Enrollment Changes

During the annual open enrollment period, your enrollment package will include information about the coverage available to you under the Plan. At that time you will have an opportunity to elect, continue or drop coverage for the coming year.

In order to change your coverage during the annual open enrollment period, you must complete, sign and return your enrollment forms (including any supporting documentation or proof required) to your HR Department by the dates outlined in your open enrollment materials. If you do not elect to make any changes, your current coverage option will continue.

If you previously waived coverage under the Plan and wish to add that coverage during open enrollment, you must provide “evidence of insurability.” You will be notified by the insurance carrier if you are approved for coverage.

Coverage changes made during open enrollment become effective on the latter of the:

- First day of the following calendar year
- Date of approval by the insurance carrier
- Date you meet the actively at work requirement

Evidence of Insurability

If evidence of insurability (EOI) is required, you must provide health and financial information to the Claims Administrator. The Claims Administrator reviews the information to determine whether your application will be approved. In some cases, providing evidence of insurability may require a physical examination by a doctor.

Qualified Status Changes Permitting an Election Change

You may change your coverage during the year if you have a qualified status change that permits you to change your election under the Plan.

A qualified status change is defined as a change in status that affects your coverage, including the events listed in the following chart:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death.
Work Schedule	A reduction or increase in hours of employment by you, including a switch between part-time and full-time.

Any change you make must be consistent with the actual event. In order to make a change, you must complete, sign and return an enrollment form to the HR Department within 30 days of the date of the qualifying family status change (for example, dependent birth date, date of marriage). You must provide proof of the qualifying event (for example, a marriage or dependent birth certificate).

If you change your coverage within 30 days of a qualified family status change, your change is effective as of the date the family status change occurs, or when your evidence of insurability is accepted by the Claims Administrator (if applicable). If you miss the deadline, you must wait until the next open enrollment period in which Plan coverage is offered to request a change.

Your Cost

You pay the full cost of coverage if you elect it. Your payroll deduction amount will appear on your pay statement. In addition, cost information is provided on your initial enrollment form. The cost for coverage is deducted from your pay on a before-tax basis; as such, any benefits you receive from the Plan will be taxable to you.

Your Long-Term Disability Coverage

This section explains some of the basics about your coverage under the Plan.

Amount of Coverage

Coverage under the Plan, when combined with income from certain other sources, can provide you with up to 50% of your monthly earnings during a covered disability, subject to the Plan's maximum.

Keep in mind that LTD benefits are paid in combination with certain other sources of disability income. This means that 50% of your monthly earnings is actually the total amount of disability income you can receive when the Plan benefit is combined with benefits from other sources. For more information, see "How Benefits Are Combined...a Few Examples" and "Other Sources of Disability Income."

How Your Monthly Earnings Determine Your Coverage

Your "monthly earnings" are used to determine your Plan coverage. Your monthly earnings are the gross amount of money paid to you for performing your job, but not including commissions, bonuses, overtime pay or other special compensation.

If Your Earnings Increase

If your monthly earnings increase, here is what happens:

- If you are actively at work or on an approved non-medical leave of absence on the date your monthly earnings increase, your coverage increases on the same date. This means if you become disabled on or after the date of the increase, any benefit you may be entitled to receive will be based on your higher monthly earnings.
- If you are absent due to sickness or injury on the date your monthly earnings increase, your coverage increase will take effect on the date you return to active work.

If Your Earnings Decrease

If your monthly earnings decrease, here is what happens:

- The amount of your coverage decreases immediately regardless of your employment status. This means if you become disabled on or after the date of the decrease, any benefit you may be entitled to receive will be based on your lower monthly earnings.
- If you are currently receiving or entitled to receive a benefit from the Plan, the amount of that benefit will not be affected by your decreased earnings. This means the amount of your benefit will continue to be based on your monthly earnings in effect when your disability began.

Maximum Benefit

The maximum monthly benefit the Plan pays is the lesser of 50% of your eligible earnings, or \$6,000.

Minimum Benefit

The minimum monthly benefit the Plan pays is the greater of:

- \$100; or
- 10% of your gross disability payment.

Taxes on Plan Benefits

Because you pay the full cost for coverage, any LTD benefits you receive from the Plan will be taxable.

When Your Coverage Ends

Your coverage ends on the earliest date one of the following events occur:

- You stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Plan is terminated; or
- You fail to pay any required contributions.

Note: If you are entitled to receive benefits for a disability which occurred before your coverage ends, LTD benefits for that disability will continue, so long as you remain disabled under the terms of the Plan.

How You Qualify for LTD Benefits

To receive benefits under the Perdue LTD Plan, you do not have to be hospitalized or confined to a home, but you must be considered disabled under the Plan. This may differ from being considered disabled for purposes of any Pension, Short Term Disability, Workers' Compensation, Social Security or other benefits you might be entitled to. When you are disabled under the Plan, your benefits begin after you meet the 180-day elimination period.

The Plan's requirement for disability changes over time.

- During the 180-day elimination period and the next 24 months, to be considered disabled under the Plan you must be unable to perform the material and substantial duties of your regular occupation, due to your sickness or injury.
- After this period, to be considered disabled under the Plan you must be unable to perform the duties of *any* gainful occupation for which you are reasonably qualified by education, training or experience, due to your sickness or injury.

At all times during your disability, to receive Plan benefits you must:

- Be under the regular care of a doctor and following the recommended care and course of treatment;
- Submit proof of your continuing disability to the Claims Administrator from time to time; and
- Earn no more than 80% of your indexed monthly earnings.

Failure to meet these requirements on a timely basis will cause your benefits to end.

The Claims Administrator will determine the extent of your disability based on medical evidence and reserves the right to have a physician of its choice examine you.

Important Terms to Know

Elimination Period – The 180-day period beginning on the first day of your disability. If your disability stops for 30 consecutive days or less during your elimination period, your disability is considered continuous, but the days you are not disabled will not count toward your 180-day elimination period. But if your disability stops for more than 30 days, you must meet a new elimination period before your Plan benefits may begin.

Material and Substantial Duties – These are the duties that are normally required for the performance of your regular occupation that cannot be reasonably omitted or modified. But if you are required to work on average in excess of 40 hours per week, the Claims Administrator will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Regular Occupation – The occupation you are routinely performing when your disability begins. The Claims Administrator looks at your occupation as it normally is performed nationwide, rather than how it is performed by a specific employer or at a specific location.

Gainful Occupation – An occupation (including self-employment) that is or can be expected to provide you with an income within 12 months of the date you return to work that exceeds 50% of your "indexed monthly earnings."

Indexed Monthly Earnings – Your monthly earnings adjusted on each July 1 by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but they will never decrease. You must be disabled for a full 12 months before July 1 to receive this adjustment. Indexed Monthly Earnings is only used to determine your percentage of lost earnings if you are disabled and working.

When LTD Benefits Begin and End

The Plan's LTD benefits begin on the day after you complete the 180-day elimination period. As long as you remain disabled under the Plan, your LTD benefits will continue.

For disabilities *other than those related to self-reported symptoms or mental illness*, your LTD benefits end when the first of these events occurs:

- You are able to work in your regular occupation on a part-time basis during the first 24 months of benefit payments from the Plan, but you choose not to do so.
- You are able to work in any gainful occupation on a part-time basis after 24 months of benefit payments from the Plan, but you choose not to do so.
- You are no longer disabled as defined under the Plan.
- You fail to submit proof of your continuing disability.
- Your disability earnings exceed the amount allowable under the Plan.
- You decline to participate in a rehabilitation program that the Claims Administrator considers appropriate for your situation and is approved by an independent doctor.
- You reach the maximum payment period for receiving benefits (described below).
- You die.

For disabilities related to self-reported symptoms or mental illness, see "Limitations Apply to Certain Disabilities."

Survivor Benefit

If you die while receiving a disability benefit, your eligible survivor may be entitled to receive a one-time payment from the Plan. Your eligible survivor is your surviving spouse. If you have no surviving spouse, your eligible survivors are your children under age 25.

The survivor benefit is paid if, on your date of death:

- Your disability had continued for at least 180 consecutive days; and
- You were receiving, or you were entitled to receive, payments under the Plan.

The amount of the benefit is equal to three monthly gross disability payments and paid in a single payment. If you have no eligible survivors, payment is made to your estate.

Maximum Payment Period

The maximum period of time for which you can receive payments under the Plan is based on your age when your disability begins as shown in the following chart.

Age When Disability Begins	Maximum Period of Time for Which LTD Payments Continue*
Less than age 62	To your Normal Retirement Age **, but not less than 60 months
Age 62 through age 64	60 months
Age 65 through age 68	To age 70 (but not less than 12 months)
Age 69 and over	12 months
* Not if your disability is related to self-reported symptoms or mental illness	
** Normal Retirement Age is your retirement age under the Social Security Act where retirement age depends upon your year of birth	

Important Terms to Know

Part-Time Basis – The ability to work and earn 20% or more of your indexed monthly earnings.

Disability Earnings – The earnings you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

If You Return to Work from a Covered Disability and Are Disabled Again

If you recover from your disability and then become disabled again, your Plan benefits will be affected.

- If you return to work for the Company for fewer than six months and become disabled again due to the same or related causes, it is counted as one continuing disability. You will not need to satisfy another elimination period. This means your Plan benefits can begin immediately with the Claims Administrator's approval.
- If you return to work for the Company for six months or longer and become disabled again due to the same or related causes, it will be treated as a separate disability. This means you will have to satisfy another 180-day elimination period and file a new claim for the Claims Administrator to approve before Plan benefits can begin again.
- If you return to work for the Company and you become disabled again due to a disability that is unrelated to your previous disability, it will be treated as a separate disability. This means you will have to satisfy another 180-day elimination period and file a new claim for the Claims Administrator to approve before Plan benefits can begin again.

Other Sources of Disability Income

The Plan is designed to work with other sources of disability income to provide your total disability income.

How Other Disability Income Affects Your Benefit

When determining your benefit, the Plan looks at your “deductible sources of income” and makes up the difference. In other words, you still may receive up to the percentage of your monthly earnings specified for your option when your benefit is combined with these deductible sources of disability income.

Deductible Sources of Income

Your gross disability payment under the Plan is reduced by payments you receive – or are entitled to receive – from certain sources. You must apply for any benefits you might be entitled to receive from these sources because the Claims Administrator has the right to estimate the amount of those benefits and to reduce your Plan benefit by the estimated amount, even if you do not apply. Deductible sources of income include, but are not limited to:

- Benefits under the United States Social Security Act, Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act (applies to payments for you, your spouse, and your children);
- Workers’ Compensation or any similar benefits;
- Any state disability benefits; and
- Any other group insurance plan (but not an individual disability income policy).

You must send the Claims Administrator a copy of all information received concerning the approval or denial of benefits from any of these sources. If you receive an award, the Claims Administrator may adjust your Plan benefit to account for any overpayment or underpayment of Plan benefits that were paid based on the estimated benefits.

In addition, your gross disability payment under the Plan will be reduced by these amounts:

- Disability benefits you receive from any Perdue pension plan;
- Retirement payments you voluntarily elect to receive from any Perdue pension plan; and
- Retirement payments you receive when you reach normal retirement age under any Perdue pension plan.

If you receive a cost of living increase from any of these sources after you begin receiving benefits from the Plan, your payment from the Plan will not be further reduced.

Important Term to Know

Gross Disability Payment – The benefit amount before any deductible sources of income and disability earnings are subtracted.

How Benefits Are Combined ... A Few Examples

This chart shows you a few examples of how coverage under the Plan may pay benefits and what your total disability income from all sources could be.

If you are covered under ...	and your LTD deductible income from other sources is ...	your coverage option would pay ...	Your total LTD income from all sources would be ...
Up to 50% of your monthly earnings)	10% of your monthly earnings	40% of your monthly earnings	50% of your monthly earnings
Up to 50% of your monthly earnings)	25% of your monthly earnings	25% of your monthly earnings	50% of your monthly earnings
Up to 50% of your monthly earnings)	40% of your monthly earnings	10% of your monthly earnings	50% of your monthly earnings

Nondeductible Sources of Income

Your gross disability payment under the Plan will not be reduced by payments you receive from sources such as:

- Profit sharing plans, 401(k) plans or thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Military pension and disability income plans;
- Credit disability insurance;
- Franchise disability income plans;
- Another employer's retirement plan;
- Individual Retirement Accounts (IRAs);
- Individual disability income plans;
- No-fault motor vehicle plans; and
- Salary continuation or accumulated sick leave plans.

However, any benefits you may receive from one of these sources may be reduced in order to coordinate with benefits from this Plan.

About Social Security Disability Insurance Benefit (DIB)

In order to receive maximum disability benefits, you will need to apply for a Social Security Disability Insurance Benefit (DIB). As soon as you become disabled, call the Social Security Administration to learn how to apply for a Social Security Disability Insurance Benefit. Social Security Disability Insurance Benefits will affect your benefit from the Plan benefits as follows:

- Your Plan benefits will be reduced by your estimated Social Security Disability Insurance Benefit, even if you are not actually receiving a Social Security Disability Insurance benefit.
- Your plan benefits will be reduced by any Social Security Disability Insurance Benefits that you, your spouse, and your children may be entitled to receive as a result of your disability.

- If your Social Security Disability Insurance Benefit is determined after your Plan benefit begins, your Plan benefit will be recalculated retroactively. If this recalculation results in an overpayment, you must repay it to the Claims Administrator. You may either make direct payments to the Claims Administrator or have your monthly LTD payments reduced until the overpayment is recovered.

If Social Security denies you benefits, the Plan may require you to file an appeal with Social Security. If you have been notified to file an appeal and you have not done so, your monthly Plan benefits may be reduced by the amount of the Social Security Disability Insurance Benefit you could be receiving had your appeal been successful. But if your application for a Social Security Disability Insurance Benefit has been denied, you have filed all available appeals, but all your appeals have been rejected, your Plan benefits will not be reduced.

If you are not eligible for a Social Security Disability Insurance Benefit because you do not have the necessary number of quarters to qualify, your Plan benefits will not be reduced.

Your Plan benefit will be reduced by your Social Security Old Age Retirement Benefit as follows:

- If you begin receiving Reduced Old Age Retirement Benefit payments your Plan will be reduced by your actual benefit payments received; and
- When you reach normal retirement age your Plan will be reduced by the Social Security Old Age Retirement Benefit you receive.

Employment While You Are Disabled

If you are able to find and accept suitable employment while you are disabled, you still may be entitled to LTD benefits for your disability as outlined in this section. The Rehabilitation Service, described in the section “Rehabilitation Benefits,” may also help you return to work.

How Your Employment Affects Your LTD Benefit

If you are working while you are disabled, the ratio of your monthly disability earnings to your indexed monthly earnings determines whether the Plan’s monthly benefits can continue, and how that benefit may be affected.

If your monthly disability earnings are less than 20% of your indexed monthly earnings, your Plan benefit may continue, provided you continue to meet the Plan’s definition of disability.

If your monthly disability earnings are 20% or more of your indexed monthly earnings – and you continue to meet the Plan’s definition of disability during your continued employment – your Plan benefit will be determined as follows:

- During the first 12 months you are working while disabled, your monthly Plan benefit will not be reduced, so long as the sum of your disability earnings and your gross disability payment is less than or equal to 100% of your indexed monthly earnings. If the combined payment is more than 100% of your indexed monthly earnings, the amount over 100% will be subtracted from your monthly payment.
- After you have worked while disabled for 12 months, future payment will be based on the percentage of income you are losing due to your disability.

When LTD Benefits Stop Due to Disability Earnings

Your LTD payments stop while you are working if:

- **During the first 24 months of Plan payments**, your monthly disability earnings exceed 80% of your indexed monthly earnings; or
- **After 24 months of Plan payments**, your monthly disability earnings exceed 60% of your indexed monthly earnings.

Rehabilitation Benefits

The Claims Administrator has a rehabilitation program available. The Claims Administrator analyzes your medical and vocational information to determine if rehabilitation services might help you return to work.

Once the initial review is completed by the Claims Administrator's rehabilitation program specialists working along with your doctor and other appropriate specialists, the Claims Administrator may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by the Claims Administrator's rehabilitation program specialists, you must receive written approval from the Claims Administrator for the program before it begins.

The rehabilitation program may include, but is not limited to, the following services:

- Coordination with the Company to assist you to return to work;
- Evaluation of adaptive equipment to allow you to work;
- Vocational evaluation to determine how your disability may affect your employment options;
- Job placement services;
- Resume preparation;
- Job seeking skills training;
- Retraining for a new occupation; or
- Assistance with relocation that may be part of an approved rehabilitation program.

If at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that the Claims Administrator considers appropriate for your disability and that has been approved by your doctor, your monthly benefits from the Plan will end.

Additional Benefits Payable When You Participate in a Rehabilitation Program

Rehabilitation Program Payment

The Claims Administrator will send you a rehabilitation payment each month, up to the maximum period of rehabilitation payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of rehabilitation payment for any one period of disability is six months.

The monthly rehabilitation payment is equal to 5% of your monthly Plan benefit. If the monthly rehabilitation payment, together with your monthly Plan benefit, exceeds your maximum monthly benefit, your monthly rehabilitation payment will be reduced by the excess amount.

Rehabilitation Daycare Payment

The Claims Administrator will send you a day care payment each month, up to the maximum period of day care payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of day care payment for any one period of disability is six months.

The monthly day care payment is equal to the amount of your eligible day care expenses, up to the maximum monthly day care amount, which is \$500 times the number of eligible children (your children age 12 or under who live with you, including your legally-adopted children [and children placed with you for adoption], stepchildren, and foster children).

Eligible day care expenses are the monthly expenses you incur for the day care of your eligible children that are:

- Charged by a child-care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- Documented by receipts from the child-care provider which include the child-care provider's Social Security number or taxpayer identification number; and
- Specified in the Claims Administrator-approved rehabilitation program as needed in order for you to participate in the program.

Rehabilitation Spouse and Elder Care Payment

The Claims Administrator will send you a spouse and elder care payment each month, up to the maximum period of spouse and elder care payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of spouse and elder care payment for any one period of disability is six months.

The monthly spouse and elder care payment is equal to the amount of your eligible spouse and elder care expenses, up to the maximum monthly spouse and elder care amount, which is \$500 times the number of eligible family members (your spouse, your parents or grandparents, or your spouse's parents or grandparents who live with you) who have a chronic illness or disability.

Eligible spouse and elder care expenses are the monthly expenses you incur for the care of your eligible family members that are:

- Charged by a licensed adult care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- Documented by receipts from the licensed adult care provider which include the provider's Social Security number or taxpayer identification number; and
- Specified in the Claims Administrator-approved rehabilitation program as needed in order for you to participate in the program.

Chronic illness or disability means one in which there is:

- A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days; or
- A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days.

Substantial assistance means:

- The physical assistance of another person without which the family member would not be able to perform an activity of daily living; or
- The constant presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to the family member while the family member is performing an activity of daily living.

Activities of daily living means:

- **Bathing** – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower
- **Continence** – The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)
- **Dressing** – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs
- **Eating** – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously
- **Toileting** – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- **Transferring** – Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either by walking, using a wheelchair or by other means.

Cognitive impairment means a loss or deterioration in intellectual capacity that is:

- Comparable to and includes Alzheimer's disease and similar forms of irreversible dementia; and
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to person, place or time; and deductive or abstract reasoning.

Substantial supervision means:

Continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect the family member from threats to the family member's health or safety.

Limitations and Exclusions

Certain limitations and exclusions apply under the Plan.

Pre-existing Condition Limitation

During the three-month period before your Plan coverage began or increased, if you received medical treatment, consultation, care, or services – including diagnostic measures, or took prescribed medicines, or followed treatment recommendation for any medical condition – that condition is considered to be a pre-existing condition. The Plan does not pay benefits for certain disabilities caused by a pre-existing condition.

Here is how it works.

- If you become disabled due to a pre-existing condition during the first 12 months after your LTD coverage begins, the Plan will not pay any benefits for that disability.
- If you become disabled more than 12 months after your coverage begins or increases, the pre-existing condition limitation will not apply.

*Tyler has a heart condition and regularly takes prescription drugs to control it. His Plan coverage begins when he joins the Company. Because he used prescription drugs **during the three-month period before his Plan coverage began**, Tyler's heart condition is considered a pre-existing condition. If during his first 12 months of coverage Tyler becomes disabled from an illness related to his heart condition, Tyler will not receive a benefit from the Plan.*

*If Tyler becomes disabled due to his heart condition **after he has been covered by the Plan for 12 months**, he will receive the Plan's monthly disability benefit.*

Limitations Apply to Certain Disabilities

Generally, monthly Plan benefits are limited to 24 months for a disability based on self-reported symptoms or due to mental illness. However, benefits may continue beyond 24 months if you are confined to a hospital or institution for treatment of a mental illness at the end of the 24-month period. In this case, benefits may continue until 90 days after your discharge. If you are confined again for at least 14 consecutive days during the 90-day recovery period after your discharge, additional benefits may be available from the Plan.

Conditions for Which the Mental Illness Limitation Does Not Apply

The 24-month limitation for disabilities due to mental illness limitation does not apply to dementia if it is the result of:

- Stroke;
- Trauma;
- Viral infection;
- Alzheimer's disease; or
- Other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Important Terms to Know

Self-Reported Symptoms – a condition which your doctor cannot verify with tests, procedures or clinical examinations generally accepted in the practice of medicine (for example, headache, pain, fatigue, stiffness, ringing in ears, dizziness, numbness or loss of energy)

Mental Illness – a psychiatric or psychological condition regardless of cause, including (but is not limited to) schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, dementia, substance related disorders and/or adjustment disorders or other conditions. These conditions usually are treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment as standardly accepted.

What Is Not Covered

The Plan does not cover disabilities caused or contributed to by:

- Intentionally self-inflicted injuries;
- Your commission of or attempt to commit a felony;
- A pre-existing condition; or
- War, declared or undeclared, or any act of war.

Your loss of an occupational license or certification does not, in itself, constitute disability. In addition, no benefits are paid for any period of disability during which you are incarcerated.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

If You Terminate Your Employment

If you stop working for the Company for any reason, your coverage under the Plan ends on the date your employment terminates. However, if you are entitled to receive benefits for a disability which occurred before your coverage ends, payments for that disability can continue subject to the terms of the Plan.

If You Are Rehired

If you were covered by the Plan on your termination date, and you are rehired by the Company at a later date, you will be treated the same as a new hire who has never worked for the Company. This means that you will have to re-satisfy all of the eligibility provisions.

If You Die

If you die while you are actively employed by the Company, your coverage ends on your last day of active employment.

If you die while receiving a disability benefit, your eligible survivor may be entitled to receive a one-time payment from the Plan as described in the “Survivor Benefit” section.

If You Are on an Approved Leave of Absence

Your continued coverage under the Plan depends upon the type of your approved leave. If you become disabled while you are covered by the Plan, any Plan benefit you may be entitled to receive will be based on your monthly earnings in effect on the date before your leave began.

FMLA Leaves of Absence

If you are on an approved leave of absence under the Family and Medical Leave Act (FMLA), your coverage will remain in effect as long as you remain an active associate of the Company, you remain on an approved FMLA leave of absence, *and* you make your required contribution.

Military Leaves of Absence

If you are on an approved military leave of absence under the Uniformed Services Employment and Re-employment Rights Act (USERRA), your coverage will remain in effect through the end of the month following the month in which your military leave begins, so long as:

- You remain an active associate of the Company; and
- You remain on an approved military leave of absence; and
- You make your required contribution.

Please remember that even though your coverage under the Plan continues during your leave, any disabilities you sustain due to an act of war are not covered by the Plan.

Personal Leaves of Absence

If you are not on a leave of absence under FMLA or USERRA, your leave of absence would fall under the Company’s Personal Leave of Absence policy. If you are on an approved personal

leave of absence, your Plan coverage continues through the end of the month following the month in which your personal leave of absence begins, provided you remain an active associate of the Company and make any required contribution. For example, if you begin your personal leave on September 2, you would be eligible to maintain your coverage under the Plan until October 31.

Filing Claims

You are encouraged to notify the Claims Administrator of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send the Claims Administrator written proof of your claim no later than 90 days after your 180-day elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

The claim form is available from your HR Department, or you can request a claim form from the Claims Administrator. If you do not receive the form within 15 days of your request, send the Claims Administrator written proof of claim without waiting for the form. You must notify the Claims Administrator immediately when you return to work in any capacity.

You and the Company must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to the claims administrator.

Information Needed as Proof Of Your Claim

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a physician;
- The appropriate documentation of your monthly earnings;
- The date your disability began;
- The cause of your disability;
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

The Claims Administrator may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 30 days of a request by the Claims Administrator.

In some cases, you will be required to give the Claims Administrator authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. The Claims Administrator will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

Claim Determination Procedures

The Claims Administrator – Prudential – will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the

period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- A description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:

- The specific reason(s) for the adverse determination;
- References to the specific Plan provisions on which the determination was based;

- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
- A description of Prudential's review procedures and applicable time limits;
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential will make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants will be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Plan is fully-insured through an insurance contract with The Prudential Insurance Company of America ("Prudential"). You pay the costs associated with coverage. These costs go toward the total premium paid by the Company to Prudential.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an "at-will employee," either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the Plan document, including the group insurance contract, that determines your rights and the rights of your dependents under the Plan. If there is a discrepancy between this summary plan description and the Plan document, including the group insurance contract, the Plan document, including the group insurance contract, will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan, the group insurance contract, or other documents maintained in conjunction with the Plan.

Benefits Provided by Group Contract

The disability income insurance benefits in the Plan are governed by a group insurance contract, underwritten by The Prudential Insurance Company of America (Prudential), and provide insured benefits under Plan. Prudential as Claims Administrator has the sole discretion to interpret the terms of the group insurance contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator will not be overturned unless arbitrary and capricious.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the Plan document, including the group insurance contract). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan will be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

LTD Plan Identification

Plan Name	The official Plan name is the Perdue Long-Term Disability Plan.
Plan Sponsor	The Plan Sponsor is Perdue Incorporated.
Type of Administration	The disability benefits under the Plan are administered by an insurance contract with: The Prudential Insurance Company of America
Plan Administrator	The Plan Administrator is: The Perdue Retirement and Employee Benefits Committee Perdue Incorporated 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Insurer/Claims Administrator	The insurer/Claims Administrator is: The Prudential Insurance Company of America. 80 Livingston Avenue Roseland, NJ 07068
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Long-Term Disability Plan is: Perdue Incorporated 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.
Plan Records and Plan Year	The Perdue Long-Term Disability Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Long-Term Disability Plan, which is a component of the Perdue Incorporated Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 503.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

THE PERDUE LONG-TERM DISABILITY INSURANCE PLAN SUMMARY PLAN DESCRIPTION

**For non-union associates in
Benefit Group 1-A**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan de seguro por discapacidad a largo plazo de Perdue Incorporated. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Revised January 1, 2010

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2010, to eligible full-time non-union associates in Benefit Group 1-A under the Perdue Long-Term Disability (LTD) Plan (referred to here simply as “the Plan”). This SPD summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior LTD Plan SPDs for associates in Benefit Group 1-A.

There are separate SPDs for associates in Benefit Groups 1, 2 and 3. If you are in one of these Benefit Groups, contact your local Human Resources (HR) Department for a copy of the SPD that applies to you. Associates in Benefit Group 4 are not eligible for coverage.

More detailed information is provided in the official plan document and group contracts, copies of which are available upon request. If there is a difference between how the SPD and the plan document and group contracts describe the eligibility rules and the benefits being provided under the Plan, the plan documents and group contracts will control and govern the operation of the Plan.

Perdue Incorporated (“the Company”) has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan document and group contract).

If you have questions regarding your benefits, please call the Corporate Benefits Line at 1-800-997-3247. Participation in the Plan is neither an offer nor a guarantee of future employment.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 37560.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Introduction

The LTD Plan provides financial protection for you by paying a portion of your income when you have a long period of disability. When combined with other sources of disability income, the Plan can replace up to 70% of your monthly earnings, up to a maximum of \$18,000 per month.

Eligibility

This section outlines the Plan's rules of eligibility for associates to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are a Salaried/Exempt associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In Benefit Group 1-A

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In one of these Benefit Groups:
 - Benefit Group 1: Salaried/Exempt
 - Benefit Group 2: Administrative/Technician – Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor – Hourly/Non-exempt, Piece Rate
 - Benefit Group 4: General Labor – Hourly/Non-exempt, Piece Rate
- In a job class covered by a collective bargaining agreement;
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Protection Against Use of Genetic Information

The Plan will not deny, limit or cancel Plan coverage for you based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please call the Corporate Benefits Line at 1-800-997-3247. The Company is the "Claims Fiduciary" for eligibility for the Plan.

Enrollment and Cost

After you start working for the Company you will be automatically enrolled. The Company pays the full cost to provide you with coverage.

Newly Hired Associates

The following sections outlines when your coverage under the Plan begins if you are a newly hired associate.

When Your Coverage Begins

Coverage begins on the first day of the calendar month on or after your first day of employment with the Company, as long as you meet the eligibility requirements and are "actively at work" on that date.

What Does "Actively at Work" Mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer's place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

Evidence of Insurability

Evidence of insurability (EOI) is not required.

Your Cost

The Company pays the full cost to provide you with coverage. As such, any benefits you receive from the Plan will be taxable to you.

Your Long-Term Disability Coverage

This section explains some of the basics about your coverage under the Plan.

Amount of Coverage

The Plan, when combined with income from certain other sources, can provide you with up to 70% of your monthly earnings during a covered disability, subject to the Plan's maximum.

Keep in mind that LTD benefits are paid in combination with certain other sources of disability income. This means that 70% is actually the total amount of disability income you can receive when the Plan benefit is combined with benefits from other sources. For more information, see "How Benefits Are Combined...a Few Examples" and "Other Sources of Disability Income."

How Your Monthly Earnings Determine Your Coverage

Your "monthly earnings" are used to determine your Plan coverage. Your monthly earnings are the gross amount of money paid to you for performing your job, but not including commissions, bonuses, overtime pay or other special compensation.

If Your Earnings Increase

If your monthly earnings increase, here is what happens:

- If you are actively at work or on an approved non-medical leave of absence on the date your monthly earnings increase, your coverage increases on the same date. This means if you become disabled on or after the date of the increase, any benefit you may be entitled to receive will be based on your higher monthly earnings.
- If you are absent due to sickness or injury on the date your monthly earnings increase, your coverage increase will take effect on the date you return to active work.

If Your Earnings Decrease

If your monthly earnings decrease, here is what happens:

- The amount of your coverage decreases immediately regardless of your employment status. This means if you become disabled on or after the date of the decrease, any benefit you may be entitled to receive will be based on your lower monthly earnings.
- If you are currently receiving or entitled to receive a benefit from the Plan, the amount of that benefit will not be affected by your decreased earnings. This means the amount of your benefit will continue to be based on your monthly earnings in effect when your disability began.

Maximum Benefit

The maximum monthly benefit the Plan pays is \$18,000.

Minimum Benefit

The minimum monthly benefit the Plan pays is the greater of:

- \$100; or
- 10% of your gross disability payment.

Taxes on Plan Benefits

Because the Company pays the full cost for coverage, any LTD benefits you receive from the Plan will be taxable.

When Your Coverage Ends

Your coverage ends on the earliest date one of the following events occur:

- You stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Plan is terminated; or
- You fail to pay any required contributions.

Note: If you are entitled to receive benefits for a disability which occurred before your coverage ends, LTD benefits for that disability will continue, so long as you remain disabled under the terms of the Plan.

How You Qualify for LTD Benefits

To receive benefits under the Perdue LTD Plan, you do not have to be hospitalized or confined to a home, but you must be considered disabled under the Plan. This may differ from being considered disabled for purposes of any Pension, Short Term Disability, Workers' Compensation, Social Security or other benefits you might be entitled to. When you are disabled under the Plan, your benefits begin after you meet the 180-day elimination period.

The Plan's requirement for disability changes over time.

- During the 180-day elimination period and the next 24 months, to be considered disabled under the Plan you must be unable to perform the material and substantial duties of your regular occupation, due to your sickness or injury.
- After this period, to be considered disabled under the Plan you must be unable to perform the duties of *any* gainful occupation for which you are reasonably qualified by education, training or experience, due to your sickness or injury.

At all times during your disability, to receive Plan benefits you must:

- Be under the regular care of a doctor and following the recommended care and course of treatment;
- Submit proof of your continuing disability to the Claims Administrator from time to time; and
- Earn no more than 80% of your indexed monthly earnings.

Failure to meet these requirements on a timely basis will cause your benefits to end.

The Claims Administrator will determine the extent of your disability based on medical evidence and reserves the right to have a physician of its choice examine you.

Important Terms to Know

Elimination Period – The 180-day period beginning on the first day of your disability. If your disability stops for 30 consecutive days or less during your elimination period, your disability is considered continuous, but the days you are not disabled will not count toward your 180-day elimination period. But if your disability stops for more than 30 days, you must meet a new elimination period before your Plan benefits may begin.

Material and Substantial Duties – These are the duties that are normally required for the performance of your regular occupation that cannot be reasonably omitted or modified. But if you are required to work on average in excess of 40 hours per week, the Claims Administrator will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Regular Occupation – The occupation you are routinely performing when your disability begins. The Claims Administrator looks at your occupation as it normally is performed nationwide, rather than how it is performed by a specific employer or at a specific location.

Gainful Occupation – An occupation (including self-employment) that is or can be expected to provide you with an income within 12 months of the date you return to work that exceeds 60% of your indexed monthly earnings if you are working.

Indexed Monthly Earnings – Your monthly earnings adjusted on each July 1 by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but they will never decrease. You must be disabled for a full 12 months before July 1 to receive this adjustment. Indexed Monthly Earnings is only used to determine your percentage of lost earnings if you are disabled and working.

When LTD Benefits Begin and End

The Plan's LTD benefits begin on the day after you complete the 180-day elimination period. As long as you remain disabled under the Plan, your LTD benefits will continue.

For disabilities *other than those related to self-reported symptoms or mental illness*, your LTD benefits end when the first of these events occurs:

- You are able to work in your regular occupation on a part-time basis during the first 24 months of benefit payments from the Plan, but you choose not to do so.
- You are able to work in any gainful occupation on a part-time basis after 24 months of benefit payments from the Plan, but you choose not to do so.
- You are no longer disabled as defined under the Plan.
- You fail to submit proof of your continuing disability.
- Your disability earnings exceed the amount allowable under the Plan.
- You decline to participate in a rehabilitation program that the Claims Administrator considers appropriate for your situation and is approved by an independent doctor.
- You reach the maximum payment period for receiving benefits (described below).
- You die.

For disabilities related to self-reported symptoms or mental illness, see "Limitations Apply to Certain Disabilities."

Survivor Benefit

If you die while receiving a disability benefit, your eligible survivor may be entitled to receive a one-time payment from the Plan. Your eligible survivor is your surviving spouse. If you have no surviving spouse, your eligible survivors are your children under age 25.

The survivor benefit is paid if, on your date of death:

- Your disability had continued for at least 180 consecutive days; and
- You were receiving, or you were entitled to receive, payments under the Plan.

The amount of the benefit is equal to three monthly gross disability payments and paid in a single payment. If you have no eligible survivors, payment is made to your estate.

Maximum Payment Period

The maximum period of time for which you can receive payments under the Plan is based on your age when your disability begins as shown in the following chart.

Age When Disability Begins	Maximum Period of Time for Which LTD Payments Continue*
Less than age 62	To your Normal Retirement Age **, but not less than 60 months
Age 62 through age 64	60 months
Age 65 through age 68	To age 70 (but not less than 12 months)
Age 69 and over	12 months
* Not if your disability is related to self-reported symptoms or mental illness ** Normal Retirement Age is your retirement age under the Social Security Act where retirement age depends upon your year of birth	

Important Terms to Know

Part-Time Basis – The ability to work and earn 20% or more of your indexed monthly earnings.

Disability Earnings – The earnings you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

If You Return to Work from a Covered Disability and Are Disabled Again

If you recover from your disability and then become disabled again, your Plan benefits will be affected.

- If you return to work for the Company for fewer than six months and become disabled again due to the same or related causes, it is counted as one continuing disability. You will not need to satisfy another elimination period. This means your Plan benefits can begin immediately with the Claims Administrator's approval.
- If you return to work for the Company for six months or longer and become disabled again due to the same or related causes, it will be treated as a separate disability. This means you will have to satisfy another 180-day elimination period and file a new claim for the Claims Administrator to approve before Plan benefits can begin again.
- If you return to work for the Company and you become disabled again due to a disability that is unrelated to your previous disability, it will be treated as a separate disability. This means you will have to satisfy another 180-day elimination period and file a new claim for the Claims Administrator to approve before Plan benefits can begin again.

Other Sources of Disability Income

The Plan is designed to work with other sources of disability income to provide your total disability income.

How Other Disability Income Affects Your Benefit

When determining your benefit, the Plan looks at your “deductible sources of income” and makes up the difference. In other words, you still may receive up to the percentage of your monthly earnings when your benefit is combined with these deductible sources of disability income.

Deductible Sources of Income

Your gross disability payment under the Plan is reduced by payments you receive – or are entitled to receive – from certain sources. You must apply for any benefits you might be entitled to receive from these sources because the Claims Administrator has the right to estimate the amount of those benefits and to reduce your Plan benefit by the estimated amount, even if you do not apply. Deductible sources of income include, but are not limited to:

- Benefits under the United States Social Security Act, Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act (applies to payments for you, your spouse, and your children);
- Workers’ Compensation or any similar benefits;
- Any state disability benefits; and
- Any other group insurance plan (but not an individual disability income policy).

You must send the Claims Administrator a copy of all information received concerning the approval or denial of benefits from any of these sources. If you receive an award, the Claims Administrator may adjust your Plan benefit to account for any overpayment or underpayment of Plan benefits that were paid based on the estimated benefits.

In addition, your gross disability payment under the Plan will be reduced by these amounts:

- Disability benefits you receive from any Perdue pension plan;
- Retirement payments you voluntarily elect to receive from any Perdue pension plan; and
- Retirement payments you receive when you reach normal retirement age under any Perdue pension plan.

If you receive a cost of living increase from any of these sources after you begin receiving benefits from the Plan, your payment from the Plan will not be further reduced.

Important Term to Know

Gross Disability Payment – The benefit amount before any deductible sources of income and disability earnings are subtracted.

How Benefits Are Combined

This chart shows you how the Plan may pay benefits and what your total disability income from all sources could be.

Your LTD deductible income from other sources is ...	The LTD plan would pay the following amount ...	Your total LTD income from all sources (including the Perdue LTD Plan) would be ...
30% of your monthly earnings	40% of your monthly earnings	70% of your monthly earnings

Nondeductible Sources of Income

Your gross disability payment under the Plan will not be reduced by payments you receive from sources such as:

- Profit sharing plans, 401(k) plans or thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Military pension and disability income plans;
- Credit disability insurance;
- Franchise disability income plans;
- Another employer's retirement plan;
- Individual Retirement Accounts (IRAs);
- Individual disability income plans;
- No-fault motor vehicle plans; and
- Salary continuation or accumulated sick leave plans.

However, any benefits you may receive from one of these sources may be reduced in order to coordinate with benefits from this Plan.

About Social Security Disability Insurance Benefit (DIB)

In order to receive maximum disability benefits, you will need to apply for a Social Security Disability Insurance Benefit (DIB). As soon as you become disabled, call the Social Security Administration to learn how to apply for a Social Security Disability Insurance Benefit. Social Security Disability Insurance Benefits will affect your benefit from the Plan benefits as follows:

- Your Plan benefits will be reduced by your estimated Social Security Disability Insurance Benefit, even if you are not actually receiving a Social Security Disability Insurance benefit.
- Your plan benefits will be reduced by any Social Security Disability Insurance Benefits that you, your spouse, and your children may be entitled to receive as a result of your disability.

- If your Social Security Disability Insurance Benefit is determined after your Plan benefit begins, your Plan benefit will be recalculated retroactively. If this recalculation results in an overpayment, you must repay it to the Claims Administrator. You may either make direct payments to the Claims Administrator or have your monthly LTD payments reduced until the overpayment is recovered.

If Social Security denies you benefits, the Plan may require you to file an appeal with Social Security. If you have been notified to file an appeal and you have not done so, your monthly Plan benefits may be reduced by the amount of the Social Security Disability Insurance Benefit you could be receiving had your appeal been successful. But if your application for a Social Security Disability Insurance Benefit has been denied, you have filed all available appeals, but all your appeals have been rejected, your Plan benefits will not be reduced.

If you are not eligible for a Social Security Disability Insurance Benefit because you do not have the necessary number of quarters to qualify, your Plan benefits will not be reduced.

Your Plan benefit will be reduced by your Social Security Old Age Retirement Benefit as follows:

- If you begin receiving Reduced Old Age Retirement Benefit payments your Plan will be reduced by your actual benefit payments received; and
- When you reach normal retirement age your Plan will be reduced by the Social Security Old Age Retirement Benefit you receive.

Employment While You Are Disabled

If you are able to find and accept suitable employment while you are disabled, you still may be entitled to LTD benefits for your disability as outlined in this section. The Rehabilitation Service, described in the section “Rehabilitation Benefits,” may also help you return to work.

How Your Employment Affects Your LTD Benefit

If you are working while you are disabled, the ratio of your monthly disability earnings to your indexed monthly earnings determines whether the Plan’s monthly benefits can continue, and how that benefit may be affected.

If your monthly disability earnings are less than 20% of your indexed monthly earnings, your Plan benefit may continue, provided you continue to meet the Plan’s definition of disability.

If your monthly disability earnings are 20% or more of your indexed monthly earnings – and you continue to meet the Plan’s definition of disability during your continued employment – your Plan benefit will be determined as follows:

- During the first 12 months you are working while disabled, your monthly Plan benefit will not be reduced, so long as the sum of your disability earnings and your gross disability payment is less than or equal to 100% of your indexed monthly earnings. If the combined payment is more than 100% of your indexed monthly earnings, the amount over 100% will be subtracted from your monthly payment.
- After you have worked while disabled for 12 months, future payment will be based on the percentage of income you are losing due to your disability.

When LTD Benefits Stop Due to Disability Earnings

Your LTD payments stop while you are working if:

- **During the first 24 months of Plan payments**, your monthly disability earnings exceed 80% of your indexed monthly earnings; or
- **After 24 months of Plan payments**, your monthly disability earnings exceed 60% of your indexed monthly earnings.

Rehabilitation Benefits

The Claims Administrator has a rehabilitation program available. The Claims Administrator analyzes your medical and vocational information to determine if rehabilitation services might help you return to work.

Once the initial review is completed by the Claims Administrator's rehabilitation program specialists working along with your doctor and other appropriate specialists, the Claims Administrator may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by the Claims Administrator's rehabilitation program specialists, you must receive written approval from the Claims Administrator for the program before it begins.

The rehabilitation program may include, but is not limited to, the following services:

- Coordination with the Company to assist you to return to work;
- Evaluation of adaptive equipment to allow you to work;
- Vocational evaluation to determine how your disability may affect your employment options;
- Job placement services;
- Resume preparation;
- Job seeking skills training;
- Retraining for a new occupation; or
- Assistance with relocation that may be part of an approved rehabilitation program.

If at any time you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that the Claims Administrator considers appropriate for your disability and that has been approved by your doctor, your monthly benefits from the Plan will end.

Additional Benefits Payable When You Participate in a Rehabilitation Program

Rehabilitation Program Payment

The Claims Administrator will send you a rehabilitation payment each month, up to the maximum period of rehabilitation payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of rehabilitation payment for any one period of disability is six months.

The monthly rehabilitation payment is equal to 5% of your monthly Plan benefit. If the monthly rehabilitation payment, together with your monthly Plan benefit, exceeds your maximum monthly benefit, your monthly rehabilitation payment will be reduced by the excess amount.

Rehabilitation Daycare Payment

The Claims Administrator will send you a day care payment each month, up to the maximum period of day care payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of day care payment for any one period of disability is six months.

The monthly day care payment is equal to the amount of your eligible day care expenses, up to the maximum monthly day care amount, which is \$500 times the number of eligible children (your children age 12 or under who live with you, including your legally-adopted children [and children placed with you for adoption], stepchildren, and foster children).

Eligible day care expenses are the monthly expenses you incur for the day care of your eligible children that are:

- Charged by a child-care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- Documented by receipts from the child-care provider which include the child-care provider's Social Security number or taxpayer identification number; and
- Specified in the Claims Administrator-approved rehabilitation program as needed in order for you to participate in the program.

Rehabilitation Spouse and Elder Care Payment

The Claims Administrator will send you a spouse and elder care payment each month, up to the maximum period of spouse and elder care payment, while you are:

- Receiving monthly disability benefits from the Plan; and
- Participating in a rehabilitation program approved by the Claims Administrator.

Your maximum period of spouse and elder care payment for any one period of disability is six months.

The monthly spouse and elder care payment is equal to the amount of your eligible spouse and elder care expenses, up to the maximum monthly spouse and elder care amount, which is \$500 times the number of eligible family members (your spouse, your parents or grandparents, or your spouse's parents or grandparents who live with you) who have a chronic illness or disability.

Eligible spouse and elder care expenses are the monthly expenses you incur for the care of your eligible family members that are:

- Charged by a licensed adult care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- Documented by receipts from the licensed adult care provider which include the provider's Social Security number or taxpayer identification number; and
- Specified in the Claims Administrator-approved rehabilitation program as needed in order for you to participate in the program.

Chronic illness or disability means one in which there is:

- A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days; or
- A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days.

Substantial assistance means:

- The physical assistance of another person without which the family member would not be able to perform an activity of daily living; or
- The constant presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to the family member while the family member is performing an activity of daily living.

Activities of daily living means:

- **Bathing** – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower
- **Continence** – The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)
- **Dressing** – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs
- **Eating** – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously
- **Toileting** – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- **Transferring** – Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either by walking, using a wheelchair or by other means.

Cognitive impairment means a loss or deterioration in intellectual capacity that is:

- Comparable to and includes Alzheimer's disease and similar forms of irreversible dementia; and
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to person, place or time; and deductive or abstract reasoning.

Substantial supervision means:

Continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect the family member from threats to the family member's health or safety.

Limitations and Exclusions

Certain limitations and exclusions apply under the Plan.

Pre-existing Condition Limitation

During the three-month period before your Plan coverage began or increased, if you received medical treatment, consultation, care, or services – including diagnostic measures, or took prescribed medicines, or followed treatment recommendation for any medical condition – that condition is considered to be a pre-existing condition. The Plan does not pay benefits for certain disabilities caused by a pre-existing condition.

Here is how it works.

- If you become disabled due to a pre-existing condition during the first 12 months after your LTD coverage begins, the Plan will not pay any benefits for that disability.
- If you become disabled more than 12 months after your coverage begins or increases, the pre-existing condition limitation will not apply.

*Tyler has a heart condition and regularly takes prescription drugs to control it. His Plan coverage begins when he joins the Company. Because he used prescription drugs **during the three-month period before his Plan coverage began**, Tyler's heart condition is considered a pre-existing condition. If during his first 12 months of coverage Tyler becomes disabled from an illness related to his heart condition, Tyler will not receive a benefit from the Plan.*

*If Tyler becomes disabled due to his heart condition **after he has been covered by the Plan for 12 months**, he will receive the Plan's monthly disability benefit.*

Limitations Apply to Certain Disabilities

Generally, monthly Plan benefits are limited to 24 months for a disability based on self-reported symptoms or due to mental illness. However, benefits may continue beyond 24 months if you are confined to a hospital or institution for treatment of a mental illness at the end of the 24-month period. In this case, benefits may continue until 90 days after your discharge. If you are confined again for at least 14 consecutive days during the 90-day recovery period after your discharge, additional benefits may be available from the Plan.

Conditions for Which the Mental Illness Limitation Does Not Apply

The 24-month limitation for disabilities due to mental illness limitation does not apply to dementia if it is the result of:

- Stroke;
- Trauma;
- Viral infection;
- Alzheimer's disease; or
- Other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Important Terms to Know

Self-Reported Symptoms – a condition which your doctor cannot verify with tests, procedures or clinical examinations generally accepted in the practice of medicine (for

example, headache, pain, fatigue, stiffness, ringing in ears, dizziness, numbness or loss of energy)

Mental Illness – a psychiatric or psychological condition regardless of cause, including (but is not limited to) schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, dementia, substance related disorders and/or adjustment disorders or other conditions. These conditions usually are treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment as standardly accepted.

What Is Not Covered

The Plan does not cover disabilities caused or contributed to by:

- Intentionally self-inflicted injuries;
- Your commission of or attempt to commit a felony;
- A pre-existing condition; or
- War, declared or undeclared, or any act of war.

Your loss of an occupational license or certification does not, in itself, constitute disability. In addition, no benefits are paid for any period of disability during which you are incarcerated.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

If You Terminate Your Employment

If you stop working for the Company for any reason, your coverage under the Plan ends on the date your employment terminates. However, if you are entitled to receive benefits for a disability which occurred before your coverage ends, payments for that disability can continue subject to the terms of the Plan.

If You Are Rehired

If you were covered by the Plan on your termination date, and you are rehired by the Company at a later date, you will be treated the same as a new hire who has never worked for the Company. This means that you will have to re-satisfy all of the eligibility provisions.

If You Die

If you die while you are actively employed by the Company, your coverage ends on your last day of active employment.

If you die while receiving a disability benefit, your eligible survivor may be entitled to receive a one-time payment from the Plan as described in the “Survivor Benefit” section.

If You Are on an Approved Leave of Absence

Your continued coverage under the Plan depends upon the type of your approved leave. If you become disabled while you are covered by the Plan, any Plan benefit you may be entitled to receive will be based on your monthly earnings in effect on the date before your leave began.

FMLA Leaves of Absence

If you are on an approved leave of absence under the Family and Medical Leave Act (FMLA), your coverage will remain in effect as long as you remain an active associate of the Company and you remain on an approved FMLA leave of absence.

Military Leaves of Absence

If you are on an approved military leave of absence under the Uniformed Services Employment and Re-employment Rights Act (USERRA), your coverage will remain in effect through the end of the month following the month in which your military leave begins, so long as:

- You remain an active associate of the Company; and
- You remain on an approved military leave of absence.

Please remember that even though your coverage under the Plan continues during your leave, any disabilities you sustain due to an act of war are not covered by the Plan.

Personal Leaves of Absence

If you are not on a leave of absence under FMLA or USERRA, your leave of absence would fall under the Company's Personal Leave of Absence policy. If you are on an approved personal leave of absence, your Plan coverage continues through the end of the month following the month in which your personal leave of absence begins, provided you remain an active associate of the Company and make any required contribution. For example, if you begin your personal leave on September 2, you would be eligible to maintain your coverage under the Plan until October 31.

Filing Claims

You are encouraged to notify the Claims Administrator of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send the Claims Administrator written proof of your claim no later than 90 days after your 180-day elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

The claim form is available from your HR Department, or you can request a claim form from the Claims Administrator. If you do not receive the form within 15 days of your request, send the Claims Administrator written proof of claim without waiting for the form. You must notify the Claims Administrator immediately when you return to work in any capacity.

You and the Company must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to the claims administrator.

Information Needed as Proof of Your Claim

Your proof of claim, provided at your expense, must show:

- That you are under the regular care of a physician;
- The appropriate documentation of your monthly earnings;
- The date your disability began;
- The cause of your disability;
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

The Claims Administrator may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 30 days of a request by the Claims Administrator.

In some cases, you will be required to give the Claims Administrator authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. The Claims Administrator will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

Claim Determination Procedures

The Claims Administrator – Prudential – will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the

period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- A description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include:

- The specific reason(s) for the adverse determination;
- References to the specific Plan provisions on which the determination was based;

- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
- A description of Prudential's review procedures and applicable time limits;
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential will make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim will be deemed denied on appeal.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants will be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Plan is fully-insured through an insurance contract with The Prudential Insurance Company of America ("Prudential"). The Company pays the costs associated with your coverage.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an "at-will employee," either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the Plan document, including the group insurance contract, that determines your rights and the rights of your dependents under the Plan. If there is a discrepancy between this summary plan description and the Plan document, including the group insurance contract, the Plan document, including the group insurance contract, will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan, the group insurance contract, or other documents maintained in conjunction with the Plan.

Benefits Provided by Group Contract

The disability income insurance benefits in the Plan are governed by a group insurance contract, underwritten by The Prudential Insurance Company of America (Prudential), and provide insured benefits under Plan. Prudential as Claims Administrator has the sole discretion to interpret the terms of the group insurance contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator will not be overturned unless arbitrary and capricious.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the Plan document, including the group insurance contract). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan will be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

LTD Plan Identification

Plan Name	The official Plan name is the Perdue Long-Term Disability Plan.
Plan Sponsor	The Plan Sponsor is Perdue Incorporated.
Type of Administration	The disability benefits under the Plan are administered by an insurance contract with: The Prudential Insurance Company of America
Plan Administrator	The Plan Administrator is: The Perdue Retirement and Employee Benefits Committee Perdue Incorporated 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Insurer/Claims Administrator	The insurer/Claims Administrator is: The Prudential Insurance Company of America. 80 Livingston Avenue Roseland, NJ 07068
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Long-Term Disability Plan is: Perdue Incorporated 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.
Plan Records and Plan Year	The Perdue Long-Term Disability Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Long-Term Disability Plan, which is a component of the Perdue Incorporated Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 503.
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or sample plan document at <https://content.carefirst.com/sbc/contracts/2017.PerdueFarms.pdf> or by logging into My Account.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	In-Network and Out of Network: \$400 Individual, \$1,000 Family. Deductible does not apply to some services, including all In-Network Preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	There are no other specific deductibles .	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In-Network and Out-of-Network: \$5,000 Individual, \$8,500 Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Prescription drug copayments are included.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover. Coinsurance amounts you pay for services from an out-of-network provider, except for emergency room services and ambulance services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.carefirst.com/perdue or call 1-844-405-2160 for a list of In-Network providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or In-Network for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

Questions: If you are a member please call the number on your ID card or log into My Account on www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
	Specialist visit	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
	Other practitioner office visit	Chiropractic: Deductible, then 20% of Allowed Benefit	Chiropractic: Deductible, then 30% of Allowed Benefit	Chiropractic: Limited to 25 visits per coverage period
	Retail Health Clinic	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
	Preventive care/ screening/immunization	No charge	Deductible, then 30% of Allowed Benefit	Out-of-network services may have limitations or exclusions. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Deductible, then 20% of Allowed Benefit X-Ray: Deductible, then 20% of Allowed Benefit	Lab Tests: Deductible, then 30% of Allowed Benefit X-Ray: Deductible, then 30% of Allowed Benefit	-----None-----
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	Retail 30-day supply: \$6 Copay. Retail 90-day supply: \$18 Copay. Mail Order 90-day supply: \$12 Copay.	Not Covered	If a brand-name drug is requested when a generic is available, you pay the generic copay plus the cost difference between the generic and the brand-name. Some non-preferred generic drugs are not covered.
	Preferred brand drugs	Retail 30-day supply: \$30 Copay. Retail 90-day supply: \$90 Copay. Mail Order 90-day supply: \$50 Copay	Not Covered	Prior authorization and step therapy are required for certain drug categories. Without prior authorization or step therapy, the drugs are not covered.
	Non-preferred brand drugs	Retail: Not Covered Mail Order: Not Covered	Not Covered	-----None-----
	Specialty drugs	Specialty Generic 30-day supply: \$6 Copay. Specialty Brand 30-day supply: \$30 Copay	Not Covered	Only specialty drugs listed on the formulary are covered. Drugs must be obtained through Accredo, except for the first fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
If you need immediate medical attention	Emergency room services	Deductible, then 10% of Allowed Benefit	Paid As In Network	Limited to emergency services (or unexpected, urgently required services). For other services, you pay your deductible, then 50% of Allowed Benefit, plus \$100 copay (copay waived if admitted).
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Paid As In Network	-----None-----
	Urgent care	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Limited to emergency services or unexpected, urgently required services within 48 hours of onset. For other services, you pay your deductible, then 20% of the Allowed Benefit.

Questions: If you are a member please call the number on your ID card or log into My Account on www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% of the Allowed Benefit.
	Physician/surgeon fee	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit: Deductible, then 20% of Allowed Benefit	Office Visit: Deductible, then 30% of Allowed Benefit	-----None-----
	Mental/Behavioral health inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% of the Allowed Benefit.
	Substance use disorder outpatient services	Office Visit: Deductible, then 20% of Allowed Benefit	Office Visit: Deductible, then 30% of Allowed Benefit	-----None-----
	Substance use disorder inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% of the Allowed Benefit.
If you are pregnant	Prenatal and postnatal care	No charge	Deductible, then 30% of Allowed Benefit	“No charge” applies to routine pre/postnatal office visits only.
	Delivery and all inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	-----None-----
If you need help recovering or have other special health needs	Home health care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Limited to 20 visits per coverage period
	Rehabilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Limited to 25 visits per coverage period for Physical, Speech, and Occupational Therapy.
	Habilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----

Questions: If you are a member please call the number on your ID card or log into My Account on www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

Perdue 000407

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Skilled nursing care	10% of Allowed Benefit	30% of Allowed Benefit	Admission must be within 14 days of a hospital confinement of at least 3 days; Limited to 60 days per coverage period
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	-----None-----
	Hospice service	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Limited to 240 days per coverage period.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	-----None-----
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check-up	Not Covered	Not Covered	-----None-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing Aids • Infertility Treatment (plan pays up to a lifetime max of \$10,000 for fertility drugs, other infertility treatments are not covered) • Long-term care | <ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs • Non-surgical care for temporomandibular joint disorder (TMJ) (plan pays up to a lifetime max of \$600) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Chiropractic care • Most coverage provided outside the United States. See www.carefirst.com | <ul style="list-style-type: none"> • Private-duty nursing • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine foot care |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|

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Perdue 000408

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or <http://www.mdinsurance.state.md.us>
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: If you are a member please call the number on your ID card or log into My Account on www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren’t clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

Perdue 000409

CareFirst SBC ID: SBC20160913MANPERDUEPPON012017

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$6,584
- Patient pays: \$956

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$400
Copays	\$11
Coinsurance	\$515
Limits or exclusions	\$30
Total	\$956

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$4,346
- Patient pays: \$1,054

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$400
Copays	\$234
Coinsurance	\$420
Limits or exclusions	\$0
Total	\$1,054

Questions: If you are a member please call the number on your ID card or log into My Account on www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

Perdue 000410

CareFirst SBC ID: SBC20160913MANPERDUEPPON012017

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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CareFirst SBC ID: SBC20160913MANPERDUEPPON012017

Foreign Language Assistance

English (English): Attention: This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their identification card. All others may call 1-855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 1-855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtètíléko: Àkíyèsí yíì ní iwífún nípa isé adójútòfò rẹ. Ó le ní àwọn déèti pàtó o sì le ní láti gbé igbésè ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yíì àti irànlówò ní èdè rẹ lófè. Àwọn omo-egbé gbòdò pe nómibà fòònu tò wà lẹyin káàdi idánimò wọn. Àwọn miràn le pe 1-855-258-6518 kí o sì dúró nípasẹ̀ ijiròrò títi a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dàhùn, sọ èdè tí o fẹ a ó sì sọ ọ pọ̀ mọ̀ ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 1-855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawang iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 1-855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 1-855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 1-855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 1-855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएं और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ̀ɔ̀-wùdù (*Bassa*) Tò Ìdùù Cáó! Bǎ nǎà kɛ bá nyo bě ké ìn gbo kpá bó ì fùà-fúá-tǐn nyɛɛ jè dyí. Bǎ nǎà kɛ bédé wé jéé bě b́é ìn ké dɛ wa mós ìn ké nyuɛɛ nyu hwè b́é wé b́éa ké zì. Ɔ mò ìn kpé b́é ìn ké bǎ nǎà kɛ kè gbo-kpá-kpá ìn mósɛ dyé dé ìn bídí-wùdù mú b́é ìn ké se wídí dò ṕéé. Kpooò nyo bě mɛ d́á fúùn-nòbà nǎà dé waa I.D. káàò d́éín nyɛ. Nyo tòò śéín mɛ d́á nòbà nǎà kɛ: 1-855-258-6518, ké ìn mɛ fò tee b́é wa kée ìn gbo ćé b́é ìn ké nòbà mòà 0 kɛɛ dyi pàdàìn hwè. Ɔ jǔ ké nyo dò dyi ìn gǎ jǔín, po wuɖu ìn mós poɛ dyie, ké nyo dò mu bó ìlìn b́é ɔ ké ìn wuɖuò mú zà.

বাংলা (*Bengali*) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 1-855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (*Urdu*) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 1-855-258-6518 پر کال کر سکتے ہیں اور 0 دہانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (*Farsi*) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 1-855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (*Arabic*) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأخريين الاتصال على الرقم 1-855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (*Traditional Chinese*)

注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 1-855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (*Igbo*) Nṛụbama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ụbọchị ndị dị mkpa, i nwere ike ime ihe tupu ụfọdụ ụbọchị njedebere. I nwere ikike inweta ozi na enyemaka a n’asụsụ gi na akwughị ugwo ọ bula. Ndị otu kwesiri ikpo akara ekwentị di n’azu nke kaadi njirimara ha. Ndị ọzọ niile nwere ike ikpo 1-855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asụsụ i choro, a ga-ejikọ gi na onye okowa okwu.

Deutsch (*German*) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 1-855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (*French*) Attention : cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le +1 855 258 6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어 (*Korean*) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 1-855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Perdue Farms, Inc.

BluePreferred Option

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance make the Group Contract's terms and provisions binding on CareFirst and the Group.

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part. Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Individuals enrolled in the Plan are also covered by the Prescription Drug Program described in Appendix A. Appendix A is not part of the Evidence of Coverage or the Group Contract and is not administered by CareFirst—it is administered by Express Scripts. It is being provided together with this Evidence of Coverage solely for the convenience of the participants. As described more fully in the Evidence of Coverage, both covered medical expenses and covered prescription drug expenses count toward the Plan's deductibles and out-of-pocket maximums.

Group Name: Perdue Farms, Inc.

Account
Number(s): 67088

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. **Preferred Health Care Providers:** For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.
2. **Non-Preferred Health Care Providers:**
 - a. **Non-Preferred health care practitioner:** For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or Carefirst's established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.
 - b. **Non-Preferred hospital or health care facility:** For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or Carefirst's established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.
 - c. **Non-Preferred Emergency Services Health Care Provider:** CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:
 - 1) The Allowed Benefit stated in paragraphs 2.a., or 2.b.
 - 2) The amount negotiated with Preferred Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Preferred Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

- 3) The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Preferred Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.
- 4) The amount that would be paid under Medicare (part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

Adverse Decision means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: **January 1st through December 31st.**

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of Eligible Members.

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member whereby CareFirst and the Member share in the payment for Covered Services.

Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that has contracted with CareFirst.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hooyer/stair lifts, ramps, shower/bath bench, items available without a prescription).

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one Copay.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

Deductible means the dollar amount of Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him/herself.

Dependent means a Member other than the Subscriber (such as the eligible spouse), meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained the Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment; or
6. Satisfaction of any combination of the above factors.

Designated Wellness Services Provider means a third party service provider contracted by Group to provide specific wellness services to Members. For purposes of this Evidence of Coverage, the Group's Designated Wellness Services Provider is a Non-Preferred Provider. Services provided by the Group's Designated Wellness Services Provider are as defined by the Group. For description of such services please contact the Group directly.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage means this agreement, which includes the acceptance, riders and amendments, if any, between the Group and CareFirst. (Also referred to as the Group Contract.)

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA means the U.S. Food and Drug Administration.

Group means the Subscriber's employer/Plan Sponsor or other organization to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the Group Contract includes any riders and/or amendments attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Habilitative mean health care services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

Infusion Therapy means treatment that places therapeutic agents into the vein, including intravenous feeding.

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

Limiting Age means the maximum age to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Director means a board certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. Not primarily for the convenience of a patient or Health Care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

Member means an individual who meets all applicable eligibility requirements, is enrolled either as a Subscriber or Dependent, and for whom payment has been received by CareFirst.

Non-Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that does not contract with CareFirst.

Non-Preferred Health Care Provider means any Health Care Provider that is not a Preferred Provider.

Occupational Therapy means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

Paid Claims means the amount paid by CareFirst for Covered Services. Inter-Plan Arrangements Fees and Compensation are also included in Paid Claims. Other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator may also be included in Paid Claims.

Physical Therapy means the short-term treatment described below that can be expected to result in an improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan of Treatment means the plan written and given to CareFirst by the attending Health Care Provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The contracted Preferred Provider has the obligation of referring Members within the network. Preferred Provider relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another.

A listing of Preferred Providers may be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any Health Care Provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means:

- A. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription."
- B. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
- C. Prescription Drugs do not include:
 - 1. Compounded bulk powders that contain ingredients that:
 - a) Do not have FDA approval for the route of administration being compounded, OR
 - b) Have no clinical evidence demonstrating safety and efficacy, OR
 - c) Do not require a prescription to be dispensed.
 - 2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:
 - a) There is no commercially available bio-equivalent Prescription Drug; OR
 - b) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Private Duty Nursing means Skilled Nursing Care that is not rendered in a hospital/Skilled Nursing Facility.

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Retail Health Clinic means mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Services provided are non-emergency and non-Urgent Care services. Examples of common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek Retail Health Clinic care, include but are not limited to: ear, bladder, and sinus infections; pink eye; flu; and strep throat.

Service Area means CareFirst's Service Area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members.

Skilled Nursing Care, depending on the place of service/benefit, means:

Home Health Care	Outpatient Private Duty Nursing	Inpatient hospital/facility /Skilled Nursing Facility
Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).	Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.	Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility).		
Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider.		
Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.		
Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.		

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition, absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist means a physician who is certified or trained in a specified field of medicine.

Specialty Drug means a Prescription Drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns – requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy means the treatment of communication impairment and swallowing disorders. Speech Therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family except for Benefits for Members Entitled to Medicare (Medicare Complementary) in which case Type of Coverage means Individual coverage. Additional categories of coverage do not apply to Benefits for Members Entitled to Medicare. Each Medicare-eligible person, including a Medicare-eligible Dependent, will be enrolled in an Individual Type of Coverage category under the Group Contract.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

- A. The individual elects coverage;
- B. The individual is entitled to Medicare, if Medicare Complementary coverage applicable;
- C. The Group accepts the individual's election and notifies CareFirst; and
- D. Payments are made on behalf of the Member by the Group.

2.2 Enrollment Opportunities and Effective Dates

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section 2.2.A and as stated in the Termination of Coverage section of the Evidence of Coverage.

When an Employee enrolls a Dependent in the Plan, the enrollment constitutes a representation by the Employee that the individual meets the definition of a Dependent and is eligible for the Plan, and that the Employee will provide evidence of eligibility on request. The enrollment also constitutes an acknowledgement by the Employee that the Plan is relying on the Employee's representation of eligibility in accepting the enrollment of the Dependent. If the Employee fails to provide evidence of eligibility when requested, that failure is evidence of fraud and material misrepresentation and the Plan may terminate coverage for the individual, which termination may be retroactive to the date as of which the individual first become ineligible.

A. Open Enrollment Period

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

- 1. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
- 2. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

B. Newly Eligible Subscriber

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period.

C. Special Enrollment Periods

Special enrollment is allowed for certain individuals in conjunction with: (1) a loss of other coverage, (2) the acquisition of certain Dependent beneficiaries or (3) losing eligibility for Medicaid or CHIP coverage, or gaining eligibility for premium assistance under Medicaid or CHIP. The Subscriber or individual seeking special enrollment must provide notice

within the time period described in the Eligibility Schedule. Enrollment will be effective as stated in the Eligibility Schedule.

These special enrollment periods are not the same as Medicare special enrollment periods.

1. Special enrollment for certain individuals who lose coverage:
 - a. CareFirst will permit current employees and Dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
 - b. Individuals eligible for special enrollment.
 - 1) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:
 - a) The employee and the Dependents are otherwise eligible to enroll;
 - b) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
 - c) The employee satisfies the conditions of paragraph 2.2C.1.c.1), 2), or 3) of this section, and if applicable, paragraph 2.2C.1.c.4) of this section.
 - 2) When Dependent loses coverage.
 - a) A Dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:
 - (1) The Dependent and the employee are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and
 - (3) The Dependent satisfies the conditions of paragraph 2.2C.1.c.1), 2), or 3) of this section, and if applicable, paragraph 2.2C.1.c.4) of this section.
 - b) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph 2.2C.1.b.2), or the employee satisfies the criteria of paragraph 2.2C.1.b.1) of this section.
 - c. Conditions for special enrollment.
 - 1) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation

coverage, the conditions of this paragraph 2.2C.1.c.1) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

- a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
 - b) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
 - c) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual;
 - d) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
 - e) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.
- 2) Termination of employer contributions. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.
- 3) Exhaustion of COBRA continuation coverage. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph 2.2C.1.c.1) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

- 4) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

2. Special enrollment with respect to certain Dependent beneficiaries:

- a. Provided the Group provides coverage for dependents, CareFirst will permit the individuals described in paragraph b. of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
- b. Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph 2.2C.1.b.1), 2), 3), 4), 5), or 6) of this section.
 - 1) Current employee only. A current employee is described in this paragraph if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.
 - 2) Spouse of a participant only. An individual is described in this paragraph if either:
 - a) The individual becomes the spouse of a participant; or
 - b) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.
 - 3) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:
 - a) The employee and the spouse become married; or
 - b) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.

- 4) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.
 - 5) Current employee and a new Dependent. A current employee and an individual who is a Dependent of the employee, are described in this paragraph if the individual becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.
 - 6) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the dependent becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.
3. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

CareFirst will permit an employee or Dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

- a. Termination of Medicaid or CHIP coverage. The employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.
- b. Eligibility for employment assistance under Medicaid or CHIP. The employee or Dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

- A. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
1. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
 2. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
- B. Qualified Medical Support Order (QMSO) means a Medical Child Support Order issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(A) of the Employee Retirement Income Security Act of 1974, as amended.

3.2 Eligibility and Termination

- A. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage the child will not be enrolled until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.

- B. Enrollment for such a child will not be denied because the child:
1. Was born out of wedlock.
 2. Is not claimed as a dependent on the Subscriber's federal tax return.
 3. Does not reside with the Subscriber.
 4. Is covered under any Medical Assistance or Medicaid program.
- C. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
1. The MCSO/QMSO is no longer in effect;
 2. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or

3. If coverage is provided under an employer sponsored health plan;
 - a. The employer has eliminated family member's coverage for all employees;
or
 - b. The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable state or federal law the child will continue in this post-employment coverage.

3.3 **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

- A. Send the non-insuring custodial parent ID cards, claims forms, the applicable evidence of coverage or member contract and any information needed to obtain benefits;
- B. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
- C. Provide benefits directly to:
 1. The non-insuring parent;
 2. The Health Care Provider of the Covered Services; or
 3. The appropriate child support enforcement agency of any state or the District of Columbia.

TERMINATION OF COVERAGE

4.1 **Disenrollment of Individual Members**

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons:

- A. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.
- B. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.
- C. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.
- D. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.
- E. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.
- F. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

4.2 **Death of a Subscriber**

If Dependent coverage is available, in the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

4.3 **Effect of Termination**

Except as provided under the Extension of Benefits for Inpatient or Totally Disabled Individuals provision, no benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

4.4 **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

5.1 Continuation of Eligibility upon Loss of Group Coverage

A. **Federal Continuation of Coverage under COBRA**

If the Group health benefit Plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit Plan may be possible. The employer offering this Group health benefit Plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the Plan Administrator.

B. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

COORDINATION OF BENEFITS; SUBROGATION

6.1 Coordination of Benefits

A. Applicability

1. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
2. If this COB provision applies, the Order of Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
 - a. Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; and
 - b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is explained in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

B. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Evidence of Coverage.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

2. An intensive care policy, which does not provide benefits on an expense incurred basis;
3. Coverage regulated by a motor vehicle reparation law;
4. The first one-hundred dollars (\$100) per day of a hospital indemnity contract;
5. An elementary and/or secondary school insurance program sponsored by a school or school system; or
6. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

1. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
3. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

C. **Order of Benefit Determination Rules**

1. **General**

When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- a. The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
- b. Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

2. **Rules**

This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

- a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - 1) Secondary to the Plan covering the person as a dependent; and

- 2) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

- b. Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

- 1) For a dependent child whose parents are married or are living together:
 - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - b) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.
- 2) For a dependent child whose parents are separated, divorced, or are not living together:
 - a) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in 1) above also shall apply if: i) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child.

- b) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:
 - (1) The Plan of the parent with custody of the child;
 - (2) The Plan of the spouse of the parent with the custody of the child;

- (3) The Plan of the parent not having custody of the child; and then
 - (4) The Plan of the spouse of the parent who does not have custody of the child.
 - 3) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in 1) and 2) of this paragraph as if those individuals were parents of the child.
- c. Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- d. Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:
 - 1) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);
 - 2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- e. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

D. Effect on the Benefits of this CareFirst Plan

- 1. **When this Section Applies**
This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.
- 2. **Reduction in this CareFirst Plan's Benefits**
When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

- E. **Right to Receive and Release Needed Information**
Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.
- F. **Facility of Payment**
A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.
- G. **Right of Recovery**
If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:
1. The persons it has paid or for whom it has paid;
 2. Insurance companies; or
 3. Other organizations.
- The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2 **Employer or Governmental Benefits**

Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

- A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
- B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

6.3 **Subrogation**

Subrogation applies when a Member has an illness or injury for which a third party may be liable. Subrogation requires the Member in certain circumstances to assign to CareFirst any rights the Member may have against a third party.

- A. The Member shall notify CareFirst as soon as reasonably possible and no later than the time the Member either submits a claim for damages to the third party, first or third party insurer or files suit, whichever first occurs, that a third party may be liable for the injuries or illnesses for which benefits are being paid.
- B. To the extent that benefits are paid under this Evidence of Coverage, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

- C. The Member shall pay to CareFirst the amount recovered by suit, settlement, or otherwise from any third party or third party's insurer, or uninsured or underinsured motorist coverage, to the extent of the benefits paid under this Evidence of Coverage.

HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in the “Choosing a Provider” subsection below. Other factors that may affect payment are found in Referrals, COB, Subrogation, the Inter-Plan Arrangements Disclosure, Inter-Plan Programs Ancillary Services, Exclusions, and Utilization Management Requirements.

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

- a. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider contracts with CareFirst or not relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.
- b. CareFirst makes payment for Covered Services but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Preferred Health Care Providers

- a. If a Member chooses a Preferred Health Care Provider, the cost to the Member is lower than if the Member chooses a Non-Preferred Health Care Provider. Throughout the Schedule of Benefits, payments are listed as either “in-network” (for a Preferred Health Care Provider) or “out-of-network” (for a Non-Preferred Health Care Provider).

If a Preferred Health Care Provider refers a Member to a Non-Preferred Health Care Provider, CareFirst will pay the in-network benefit, but the Member will still be responsible for the difference between CareFirst’s payment and the Non-Preferred Health Care Provider’s charge.

- b. Claims will be submitted directly to CareFirst by the Preferred Health Care Provider.
- c. CareFirst will pay benefits directly to the Preferred Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.
- d. The Member is responsible for any applicable Deductible and Coinsurance or Copayment, as stated in the Schedule of Benefits.

3. Non-Preferred Health Care Providers
 Except as otherwise authorized by CareFirst, if a Member chooses a Non-Preferred Health Care Provider, Covered Services may be eligible for reduced benefits. When Covered Services are provided by a Non-Preferred Health Care Provider, out-of-network benefits apply.
 - a. Claims may be submitted directly to CareFirst or its designee by the Non-Preferred Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
 - b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Preferred Health Care Provider, at the discretion of CareFirst.
 - c. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the appropriate department of an appropriate State (as designated in the order) or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.
 - d. Non-Preferred Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Preferred Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Member is responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.
4. Ambulance Services Providers
 - a. For purposes of calculating the Member payment for Ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide	
If a Member receives Covered Services from:	Member liability:
Preferred Ambulance Services Provider	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Ambulance Services Provider	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Ambulance Services Provider's actual charge.

- b. If a Member receives services from a Preferred Provider, the cost to the Member is lower than if the Member receives services from a Non-Preferred Provider.
- C. **Notice of Claim**
 A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

D. **Claim Forms**

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

E. **Proofs of Loss**

In order to receive benefits for services rendered by a Health Care Provider who does **not** contract with CareFirst, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

1. Claims for medical benefits must be submitted within fifteen (15) months following the dates services were rendered.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the member, not later than one year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

F. **Time of Payment of Claims**

Benefits payable under this Evidence of Coverage will be paid not more than thirty (30) days after receipt of written proof of loss.

G. **Claim Payments Made in Error**

If CareFirst makes a claim payment to or on behalf of a Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

H. **Assignment of Benefits**

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Preferred Health Care Provider rendering Covered Services. A Member may not assign his or her right to bring a lawsuit under ERISA against Perdue, the Plan, the Plan Administrator, or CareFirst.

I. **Evidence of Coverage**

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable.

J. **Notices**

Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail or by first class mail to the most recent address for the Member in CareFirst's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

K. **Privacy Statement**

CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

L. **Prescription Drug Rebate Sharing**

CareFirst may be eligible for rebates from Prescription drug manufacturers upon negotiating directly with manufacturers.

CareFirst and the Sponsor agree to the extent to which any such rebates are shared.

REFERRALS

Referral Requirements

- A. Written referrals are not required.
- B. However, a Preferred Provider may refer a Member to a Non-Preferred Provider. Referrals made by a Preferred Provider to a Non-Preferred Provider are good for 120 days except as stated in Subsection C below. A referral will specify the number of visits and types of services approved. Covered Services received by referral will be paid “in-network.” Covered Services Incurred after the expiration of the referral, or Covered Services beyond what is specified in the referral, will be paid “out-of-network.”
- C. Referral to a Specialist or Non-Physician Specialist
 - 1. Non-Physician Specialist means a Health Care Provider who is not a physician who is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any state or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.
 - 2. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and
 - a. CareFirst does not contract with a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
 - b. CareFirst cannot provide reasonable access to a contracted Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
 - 3. For purposes of calculating any Member payment, CareFirst will treat the services provided by the Specialist or Non-Physician Specialist as if the services were provided by a Preferred Health Care Provider.

D. Referrals Quick Reference

While written referrals are not required, Covered Services with a referral will be available as follows:

For Covered Services:			
If a Member sees a:	With referral:	Without referral:	Member liability:
Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.		No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.	Covered Services will be paid at the out-of-network level of benefits if out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted for Covered Services: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Health Provider's actual charge.

This Referrals Quick Reference guide is subject to the terms stated in the Referral to a Specialist or Non-Physician Specialist section, above.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the utilization management requirements or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

Most Prescription Drugs classified as Specialty Drugs require prior authorization; prior authorization applies to Specialty Drugs covered under the medical portion of this Evidence of Coverage (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings). Specialty Drugs are defined in the Definitions section of this Evidence of Coverage. Preferred Health Care Providers will obtain prior authorization from CareFirst on behalf of the Member. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization/a Plan of Treatment. Failure to obtain prior authorization may result in denial of the claim.

A. Plan of Treatment

Certain outpatient services indicated throughout this Evidence of Coverage require CareFirst's approval of a Plan of Treatment before benefits for Covered Services are provided; a penalty may apply if such approval is not obtained.

1. A health care practitioner must complete and submit a Plan of Treatment.
2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.
3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.
4. Within the Service Area, a Preferred Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Preferred Health Care Provider or a Non-Preferred Health Care Provider.
5. Services for which CareFirst must approve a Plan of Treatment:
 - a. Controlled Clinical Trial Patient Cost coverage

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
 - b. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

c. Home Health Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late (forty-eight (48) hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

d. Hospice Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing hospice care, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

e. Private Duty Nursing

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

B. Hospital Pre-Certification and Review

A Preferred Health Care Provider, in and out of the Service Area, will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Preferred Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

- a. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.
- b. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.
- c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.
- d. Pre-operative days will not be approved for procedures unless Medically Necessary.
- e. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.
- f. CareFirst's payment will be based on the inpatient days approved by the reviewer.
- g. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.

- h. Hospital Pre-Certification and Review is not applicable to maternity admissions, and admissions for cornea and kidney transplants.
2. Non-Emergency (Elective) Admissions
- a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.
 - b. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.
 - c. For Out-of-Network Covered Services:
 - 1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.
3. Emergency (Non-Elective) Admissions
- a. The Member, the Health Care Provider or another person acting on behalf of the Member must notify the reviewer within twenty-four (24) hours following the Member's admission, or as soon thereafter as reasonably possible.
- The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify the reviewer of the emergency admission within twenty-four (24) hours if the Member's medical condition prevented the hospital from determining:
- 1) The Member's insurance status; and
 - 2) The reviewer's emergency admission notification requirements.
- b. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:
 - 1) During the first twenty-four (24) hours the Member is in an inpatient facility; or
 - 2) Until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a Member has been admitted and shall state the reasons for the admission.

- c. The reviewer will make all initial determinations on whether to approve a non-elective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

For non-elective admissions for which the reviewer receives notice but does not approve inpatient benefits, CareFirst will notify the hospital attending Health Care Provider that inpatient benefits will not be paid as of the date of notification.

- 1) A Member will have to pay:
 - a) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.
 - b) Non-Preferred Health Care Providers if a non-elective admission results in payment denial.
 - 2) A Member will not have to pay Preferred Providers:
 - a) If the Member is admitted and the admission is not Medically Necessary;
 - b) If a non-elective admission results in payment denial.
- d. For Out-of-Network Covered Services:
- 1) CareFirst will not provide benefits for a non-elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the non-elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

- 4. Continued Stay Review
The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.
- 5. Discharge Planning
The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.
- 6. Program Monitoring
 - a. The Member's medical record will be reviewed by the reviewer.

- b. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.
 - c. During and after discharge, the reviewer may review the medical records to:
 - 1) Verify that the services are covered under the Evidence of Coverage;
 - 2) Ensure that the Health Care Provider is substantially following the Plan of Treatment.
7. Notice and Appeals
- a. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.
 - b. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.
 - 1) If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.
 - 2) For instructions on how to appeal an Adverse Decision, refer to the Claims Procedures of this Evidence of Coverage.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services

Overview

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan. The Inter-Plan Programs are described generally below.

When a Member receives care outside of CareFirst’s service area, it will be received from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. CareFirst explains below how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst’s service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst’s service area and care received outside the geographic area CareFirst serves is stated in the Definitions.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when a Member receives Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When a Member receives Covered Services outside CareFirst’s service area and the claim is processed through the BlueCard Program, the amount a Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount a Member pays for Covered Services under this arrangement will be calculated based on the negotiated price/lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to a Member, the Member will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, a Member will incur no liability, other than any related Member cost sharing.

C. Special Cases: Value-Based Programs

BlueCard® Program

If a Member receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to CareFirst through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If CareFirst has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, CareFirst will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside CareFirst's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount a Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, a Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

F. BlueCard Worldwide® Program

If a Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Member may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if a Member contacts the BlueCard Worldwide Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit Member claims to the BlueCard Worldwide Service Center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services.

Members must contact CareFirst to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BlueCard Worldwide Claim**

When Members pay for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If Members need assistance with their claim submission, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs);
2. Medical Devices and Supplies; and
3. Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care).

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider or a Health Care Provider who contracts with the local Blue Cross and/or Blue Shield Licensee in that geographic area as stated in the Inter-Plan Arrangements Disclosure.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: <ul style="list-style-type: none">• Shipped to; or• Purchased at a retail store.	
Specialty Prescription Drugs	Ordering/prescribing physician is located.	

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE (Medicare Complementary)

The provisions in this section apply to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in this Evidence of Coverage. Benefits that are covered by Medicare are subject to the provisions in this section.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures; however, the Utilization Management Requirements of this Evidence of Coverage do not apply to persons for whom Medicare is the primary carrier.

Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Providers contracted with CareFirst, all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

This coverage is not Medicare supplemental coverage. This coverage provides benefits for some charges and services not covered by Medicare. It is not designed to fill the "gaps" of Medicare.

Covered Services under Medicare Complementary are the same as under the Description of Covered Services. Only the manner of payment is different:

A. Coverage Secondary to Medicare

Except where prohibited by law, CareFirst benefits are secondary to Medicare.

B. Medicare as Primary

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare:
 - a. For any Health Care Provider who accepts Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge.
 - b. For any Health Care Provider who does not accept Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the limitation set by Medicare.
2. **For a Member who Elects Medicare Part B:** CareFirst will coordinate as described above and pay benefits based on Medicare's payment. For example, after meeting the Part B deductible, Medicare pays 80% of the Medicare approved amount for most doctor services; the basis for CareFirst's payment is the remaining 20% of the Medicare approved amount (the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge/limitation set by Medicare).

a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming:	
Part B deductible has been met; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%; and Medicare approved charge does not exceed limitation set by Medicare, if applicable	
Medicare approved amount	\$ 1,000.00
Multiplied by 80% equals Medicare payment	\$ 800.00
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

3. **For a Member who Does not Elect Part B:** CareFirst will reduce its payment to “carve-out” or reject the 80% coinsurance Medicare would have paid if the Member had elected Part B.

- a. If the amount Medicare would have paid is available, CareFirst will coordinate as described above, “carving-out” or rejecting the amount Medicare would have paid. CareFirst will base its reduced Coinsurance payment on the amount Medicare would have paid if the Member had elected Part B.
- b. If the amount Medicare would have paid is not available, CareFirst will base its Coinsurance payment on 20% of the Allowed Benefit. The 80% reduction to the Allowed Benefit represents the amount that Medicare theoretically would have paid if the Member had elected Part B.
- c. Numerical Examples for a Member who Does not Elect Part B:
 - 1) In the first numeric example below, CareFirst's Allowed Benefit is assumed to be the same as the Medicare approved amount in the above example for a Member who elects Medicare Part B. In this example, CareFirst's payment does not differ; however, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available;	
CareFirst Deductible, if applicable, has been met;	
CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 1,000.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

- 2) In the second numeric example below, CareFirst's Allowed Benefit is assumed to differ from the Medicare approved amount in the above example for a Member who elects Medicare Part B. Again, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available;	
CareFirst Deductible, if applicable, has been met;	
CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 500.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 100.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 100.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 80.00

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists other features that affect Member coverage, including, if applicable, the Deductible, Out-of-Pocket Maximum, and specific benefit limitations. It is also important to review the section entitled "Exclusions."

PREVENTIVE AND WELLNESS SERVICES

A. Covered Services

Benefits are available for:

Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Is approved by:
 - a. The National Institutes of Health (NIH) or a Cooperative Group.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - 1) To be comparable to the system of peer review of studies and investigations used by the NIH, and
 - 2) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - h. The FDA in the form of an investigational new drug application.
 - i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Evidence of Coverage for non-Investigational treatments.

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:
 - a. Treatment provided for a life-threatening condition; or,
 - b. Prevention, early detection, and treatment studies on cancer.
2. Coverage will be provided only if:
 - a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer; or,
 - b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;
 - c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,
 - e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.
 - f. Prior authorization has been obtained from CareFirst.
3. Coverage is provided for the Patient Cost, including Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

DIABETES EQUIPMENT

Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

DIABETES SUPPLIES

Coverage will be provided for all Medically Necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

DIABETES SELF-MANAGEMENT TRAINING

1. Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
2. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

1. With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the Member.
2. Medically Necessary air transportation, surface, and ground ambulance services, as determined by CareFirst.
 - a. Foreign Transportation. If the Member requires professional medical care for an injury or illness while traveling outside the United States, CareFirst or its authorized agent will cover the reasonable and necessary costs to transport the Member to a location where more appropriate medical care is available.
3. Urgent Care services.

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:
 - a. If the Member is:
 - 1) Seven years of age or younger, or developmentally disabled;
 - 2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and
 - 3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - b. Or, if the Member is:
 - 1) Seventeen years of age or younger;
 - 2) An extremely uncooperative, fearful, or uncommunicative individual;
 - 3) An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - 4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - c. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - d. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - 1) A fully accredited specialist in pediatric dentistry;
 - 2) A fully accredited specialist in oral and maxillofacial surgery; and
 - 3) A dentist who has been granted hospital privileges.
 - e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

HOME HEALTH CARE

A. Definitions

Home Health Care means the continued care and treatment of a Member by a Health Care Provider in the home if:

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and
2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

Home Health Care Visits:

1. Each visit by a member of a Home Health Care team is considered one Home Health Care Visit; and
2. Up to four (4) hours of Home Health Care service is considered one Home Health Care visit.

B. Covered Services

1. Home Health Care, as defined above.
2. Home Visits Following Childbirth, including any services required by the attending Health Care Provider:
 - a. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or ninety-six (96) hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;
 - b. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):
 - 1) One home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge;
 - 2) An additional home visit following childbirth if prescribed by the attending Health Care Provider.
 - c. An attending Health Care Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Health Care Provider, attending the Member or newborn Dependent child(ren).
 - d. Home visits following childbirth must be rendered, as follows:
 - 1) In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
 - 2) By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

3. Home Visits Following the Surgical Removal of a Testicle

- a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - 1) One home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and
 - 2) An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

C. Limitations

- 1. The Member must be confined to “home” due to a medical condition. “Home” cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.
- 2. The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
- 3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. “Skilled Nursing Care,” for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.
- 4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).
- 5. See additional limitations in the Schedule of Benefits.

HOSPICE CARE

A. Definitions

Caregiver means a person who is not a Health Care Provider who lives with or is the primary caregiver of the Member in the home. The Caregiver can be a relative by blood, marriage or adoption or a friend of the Member, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

1. Inpatient hospice facility services;
2. Part-time nursing care by or supervised by a registered graduate nurse;
3. Counseling, including dietary counseling, for the Member;
4. Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the Member;
5. Medical care by the attending physician;
6. Other Medically Necessary health care services at CareFirst's discretion.

Additionally, hospice care benefits are available for a Member's family (family is the spouse, parents, siblings, grandparents, child(ren), and or Caregiver) for periodic family counseling before the Member's death, and bereavement counseling.

INFERTILITY SERVICES

A. Definitions

Infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.

B. Covered Services

1. Benefits are available for the diagnosis of Infertility excluding artificial insemination/intrauterine insemination and in vitro fertilization.
2. Under the Prescription Drug Coverage (see APPENDIX A), benefits are available for fertility drugs, up to a lifetime maximum of \$10,000. Benefits are not otherwise available for the treatment of Infertility.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(ambulatory services; hospitalization; laboratory services)

A. Covered Services

1. Inpatient/outpatient medical care and consultations.

Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Health Care Provider and a Member. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

2. Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

3. Surgery, as follows:

a. Oral surgery, limited to:

- 1) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity not solely involving teeth.
- 2) Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

- 1) The injury did not arise while or as a result of biting or chewing; and
- 2) Treatment is commenced within twelve (12) months of the injury or, if due to the nature of the injury treatment could not begin within twelve (12) months of the injury, treatment began within twelve (12) months of the earliest date that it would be medically appropriate to begin such treatment.

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

b. Medically Necessary surgical procedures, as determined by CareFirst.

If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

- 1) If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically

integral to the primary procedure, CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.

- 2) If the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.
- c. Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are (i) Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention, or (ii) described in the following section, entitled "Mastectomy Related Services."
4. Inpatient/outpatient assistant if the surgery requires surgical assistance as determined by CareFirst.
5. Inpatient/outpatient anesthesia services by a Health Care Provider other than the operating surgeon.
6. Inpatient/outpatient chemotherapy.
7. Home Infusion Therapy.
8. Inpatient/outpatient radiation therapy.
9. Inpatient/outpatient renal dialysis.
10. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
11. Administration of injectable Prescription Drugs by a Health Care Provider.
12. Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), allergy testing.
13. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/ Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.
14. Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from oral surgery, and otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.
15. Elective sterilization.
16. Skilled Nursing Facility services.

17. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
18. Treatment of temporomandibular joint (TMJ) dysfunction: Medically Necessary conservative treatment and surgery, as determined by CareFirst.
19. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
2. Breast prostheses prescribed by a physician for a Member who has undergone a mastectomy and has not had breast reconstruction;
3. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member;
4. Inpatient hospital services for a minimum of forty-eight (48) hours following a mastectomy as a result of breast cancer. A Member may request a shorter length of stay if the Member decides, in consultation with the attending physician, that less time is needed for recovery.
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - 1) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
 - 2) An additional home visit if prescribed by the Member's attending physician.
 - b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician.

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services including:
 - a. Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:
 - 1) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support supplies and consultation; and
 - 2) Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B” or provided in the comprehensive guidelines for women’s preventive health supported by the Health Resources and Services Administration.
 - b. Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not identified in section A.1.a. above, and Ancillary Services provided during those visits. Benefits include Medically Necessary laboratory diagnostic tests and services not identified in section A.1.b. above, including, but not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
 - c. Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event;
 - d. Medically Necessary services for the normal newborn (an infant born at approximately forty (40) weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
 - e. Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;
 - f. Circumcision.
2. Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - a. A minimum of:
 - 1) forty-eight (48) hours following an uncomplicated vaginal delivery;
 - 2) ninety-six (96) hours following an uncomplicated cesarean section.
 - b. Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.
3. Coverage for victims of rape or incest.

4. Birthing classes: one course per pregnancy at a CareFirst approved facility.
5. Birthing centers.
6. Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
7. Benefits are available for comprehensive lactation support and counseling, by a Health Care Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

1. Is primarily and customarily used to serve a medical purpose;
2. Is not useful to a person in the absence of illness or injury;
3. Is ordered or prescribed by a physician or other qualified practitioner;
4. Is consistent with the diagnosis;
5. Is appropriate for use in the home;
6. Is reusable; and
7. Can withstand repeated use.

Medical Device means Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

1. Are primarily and customarily used to serve a medical purpose;
2. Are not useful to a person in the absence of illness or injury;
3. Are ordered or prescribed by a physician or other qualified practitioner;
4. Are consistent with the diagnosis;
5. Are appropriate for use in the home;
6. Cannot withstand repeated use; and
7. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
4. May be purely passive support or may make use of spring devices;
5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or

2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a Health Care Provider; and
5. Is removable and attached externally to the body.

B. Covered Services

1. **Durable Medical Equipment**

Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

2. **Medical foods and nutritional substances**

Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

3. **Medical Supplies**

Benefits are available for Medical Supplies as such supplies are defined above.

4. **Orthotic Devices, Prosthetic Devices**

Benefits include:

- a. Supplies and accessories necessary for effective functioning of the Orthotic or Prosthetic Device;
- b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
- c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

5. **Repairs.** Benefits for the repair, maintenance or replacement of an Orthotic or Prosthetic Device require authorization or approval by CareFirst. Benefits are limited to:

- a. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
- b. Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.

- c. Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

**MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES,
INCLUDING BEHAVIORAL HEALTH TREATMENT**

Inpatient/outpatient mental health and substance use disorder services, including behavioral health treatment.

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Recipient/Donor benefits

When Member is a:	Benefits are available for:
Recipient	Benefits are available for both the Member recipient and the non-Member donor. Donor benefits are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services;
2. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant;
3. Immunosuppressant maintenance drugs when prescribed for a covered transplant;
4. Organ transplant procurement benefits for the recipient:
 - a. Health services and supplies used by the surgical team to remove the donor organ;
 - b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor;
 - c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
5. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;
2. Conform to all laws that apply to organ transplants;

3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;
2. Diagnosis;
3. Type of surgery;
4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

Benefits are available for Medically Necessary outpatient Private Duty Nursing, as determined by CareFirst. Benefits are not provided for Private Duty Nursing rendered in a hospital.

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits are available through Express Scripts—not through CareFirst—for Pharmacy-dispensed Prescription Drugs. Please see APPENDIX A, at the end of this Booklet, for a description of the Prescription Drug Program.	Benefits are available, and limited to, Prescription Drugs dispensed in the office of a Health Care Provider. Contraceptives: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.

PROFESSIONAL NUTRITIONAL COUNSELING/MEDICAL NUTRITION THERAPY

A. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

B. Covered Services

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

REHABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**

Benefits are available for inpatient Rehabilitative Services.

2. **Outpatient Rehabilitative Services**

Benefits are available for the following outpatient Rehabilitative Services:

a. Occupational Therapy;

b. Physical Therapy; and

c. Speech Therapy.

3. **Cardiac Rehabilitation**

Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide Cardiac Rehabilitation.

Benefits will not be provided for maintenance programs.

4. **Pulmonary Rehabilitation**

Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide pulmonary rehabilitation.

Benefits will not be provided for maintenance programs.

5. Visual Therapy.

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Preferred Health Care Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
 2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
 3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet
 - Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
 - Cosmetic services (except for Mastectomy—Related Services).
 - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
 - All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the Member, unless otherwise a Covered Service.
 - All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-

the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.

- Any procedure or treatment designed to alter an individual’s physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to health education classes and self-help programs, except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary rehabilitation programs and services provided by the Group’s Designated Wellness Services Provider.
- Medical or surgical treatment for obesity, unless otherwise specified in the Description of Covered Services.
- Medical or surgical treatment or regimen for reducing or controlling weight for morbid obesity.

These exclusions do not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.

- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.
- Non-medical Health Care Provider services, including, but not limited to:
 1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
 2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider’s medical practices services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.
- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider’s charges and billed for by them.
- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.

- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).
- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.
- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp

admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.

- Immunizations solely for foreign travel.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in the Description of Covered Services.
- Hearing care except as otherwise stated.
- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.
- Work Hardening Programs. Work Hardening Programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

Emergency Services

- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

General anesthesia and associated hospital or ambulatory surgical facility services for dental care

- Dental care for which general anesthesia is provided.

Home Health Care

- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.
- Respite care.

Infertility services

Medical or surgical treatment for Infertility, except as stated in the Description of Covered Services.

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.
- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.
- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).
- Acupuncture.
- Cleft lip or cleft palate, or both: inpatient or outpatient expenses arising from orthodontics.
- Inpatient Private Duty Nursing.
- Procedures to reverse sterilization.
- Surgical removal of impacted teeth.
- Elective Abortion unless a physician certifies in writing that the pregnancy would endanger the life of the mother, expenses are incurred to treat medical complications due to the abortion, or the pregnancy is the result of rape or incest.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

Mental health and substance use disorder services, including behavioral health treatment

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses Incurred for the location of a suitable donor; e.g., search of a population or mass screening.

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services or in APPENDIX A.
- Routine immunizations and boosters (except as stated in the Description of Covered Services, Preventive and Wellness Services).

Rehabilitative Services

- Services delivered through early intervention and school services.
- Applied Behavioral Analysis services.
- Habilitative Services.

ELIGIBILITY SCHEDULE

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group.	
Spouse	Coverage for a Subscriber's spouse is available.	
Domestic Partner	Coverage for a Subscriber's Domestic Partners is not available.	
Dependent children	Coverage for a Subscriber's Dependent children, excluding children of a Domestic Partner, is available. (For these purposes, the children of a Domestic Partner are not considered the Subscriber's Dependent children.)	Limiting Age Up to age 26
Unmarried incapacitated Dependent children	<p>A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:</p> <ol style="list-style-type: none"> 1. The Dependent child is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty-one (31) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated. 	Limiting Age Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber	<p>A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.</p> <p>A Subscriber who is not enrolled when the Group receives an MCSO is eligible for coverage effective on the date specified in the MCSO, provided that the MCSO is determined to be a QMSO.</p>
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	<p>The employee must notify the Group, and the Group must notify CareFirst no later than thirty (30) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.</p>
Special enrollment for certain dependent beneficiaries	<p>The employee must notify the Group, and the Group must notify CareFirst during the 30-day special enrollment period beginning on the date of the marriage, birth, or adoption or placement for adoption.</p> <p>A new Subscriber and/or his/her Dependents is effective as follows:</p> <p>In the case of marriage: the date of marriage.</p> <p>In the case of a newly born child: the date of birth.</p> <p>In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.</p>
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).</p> <p>A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.</p>

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the date eligibility ceases as determined by the Group.
Dependent child	A Dependent child will remain covered until the birthday when the Dependent child reaches the Limiting Age for a Dependent child.
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the date eligibility ceases as determined by the Group.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.
Subscriber changes the Type of Coverage to an Individual or other non-family contract (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Coverage will terminate on the date the Subscriber changes the Type of Coverage to an Individual or other non-family contract.
Death of a Subscriber	Coverage of any Dependents will terminate on the date determined by the Group.

SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced. See Utilization Management Requirements for these rules.

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

DEDUCTIBLE			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$400	\$1,000	\$400	\$1,000
Applicable to all in-network benefits, except as stated in the Description of Covered Services.		Applicable to all out-of-network benefits, except as stated in the Description of Covered Services.	
In-Network and Out-of-Network			
The in-network and out-of-network Deductible will be a combined amount.			
The Deductible is calculated based on the Allowed Benefit of Covered Services.			
When the Type of Coverage is Individual, CareFirst will pay for all or part of remaining Covered Services when the Member reaches the individual Deductible amount.			
When the Type of Coverage is family, the family Deductible amount is calculated in the aggregate.			
CareFirst pays benefits for a family Member in a family Type of Coverage who reaches the individual Deductible amount before the family Deductible amount is reached.			
A family Member may not contribute more than the individual Deductible amount to the family Deductible amount.			
The following amounts are included/excluded from the Deductible:		Included	Excluded
Amounts in excess of the Allowed Benefit		No	Yes

OUT-OF-POCKET MAXIMUM			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$5,000	\$8,500	\$5,000	\$8,500
In-Network and Out-of-Network			
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.			
When the Type of Coverage is Individual, CareFirst will pay for all or part of remaining Covered Services when the Member reaches the individual Out-of-Pocket amount.			
When the Type of Coverage is not Individual, the individual Out-of-Pocket Maximum amount is embedded in the family Out-of-Pocket Maximum amount.			
An individual may not contribute more than the individual Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum amount.			
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.			
The following amounts are included/excluded from the Out-of-Pocket Maximum:	Included	Excluded	
Amounts in excess of the Allowed Benefit (both in-network and out-of-network amounts)	No	Yes	
In-network Coinsurance (Member's share)	Yes	No	
In-network Copays	Yes	No	
In-network Deductible	Yes	No	
Out-of-network Coinsurance (Member's share)	For Emergency Room Services and Ambulance Services: Yes	For Emergency Room Services and Ambulance Services: No	
	For all other Covered Services: No	For all other Covered Services: Yes	
Out-of-network Copays	No	Yes	
Out-of-network Deductible	For Emergency Room Services and Ambulance Services: Yes	For Emergency Room Services and Ambulance Services: No	

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are not Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

IMPORTANT NOTE REGARDING PRESCRIPTION DRUG COVERAGE

Benefits for pharmacy-dispensed Prescription Drugs are not available under this Evidence of Coverage. However, the Group may provide coverage for pharmacy-dispensed prescription drug benefits under a separate plan from a third party insurer. Please contact the Group for further details.”

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Adult preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Chlamydia screening	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Colorectal cancer screening		
Hepatitis C screening		
Human papillomavirus screening		
Mammography/breast cancer screening		

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Osteoporosis prevention		
Prostate cancer screening		
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services	Limitations Ambulance services are limited, as follows: <ul style="list-style-type: none"> Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance. 	
Ambulance Services	80% of Allowed Benefit	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Limitations Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes equipment	80% of Allowed Benefit	70% of Allowed Benefit
Diabetes supplies	80% of Allowed Benefit	70% of Allowed Benefit
Diabetes self-management training	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services		
Emergency Services in a hospital emergency room/department		
Hospital emergency room/department and ancillary services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	90% of Allowed Benefit	
Outpatient professional practitioner(s) in hospital emergency room/department	90% of Allowed Benefit	
Member admitted as inpatient	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Non-Emergency Services in a hospital emergency room/department		
Hospital emergency room/department (facility)	50% of Allowed Benefit after \$100 Copay *	
Outpatient professional practitioner(s) in hospital emergency room/department	50% of Allowed Benefit	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office	80% of Allowed Benefit	70% of Allowed Benefit
Urgent Care center: Emergency Services within forty-eight (48) of onset of Emergency Medical Condition	90% of Allowed Benefit	50% of Allowed Benefit
Urgent Care center: Emergency Services after forty-eight (48) of onset of Emergency Medical Condition	80% of Allowed Benefit	50% of Allowed Benefit
Urgent Care center: Non-Emergency Services	80% of Allowed Benefit	50% of Allowed Benefit
Dental services related to accidental injury or trauma	Limitations Treatment must be provided within twelve (12) months from the date of the injury.	
	80% of Allowed Benefit	70% of Allowed Benefit

*Copay waived if admitted.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
General anesthesia and associated hospital or ambulatory surgical facility services for dental care	Limitations An approved Plan of Treatment may be required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	Limitations An approved Plan of Treatment is required for Home Health Care. Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS) provided under the Total Care and Cost Improvement Program. Hospital/home health agency: Twenty (20) Home Health Care Visits per Benefit Period.	
	Hospital/home health agency	90% of Allowed Benefit
	Home visits following childbirth	70% of Allowed Benefit
	Home visits following mastectomy	90% of Allowed Benefit
	Home visits following the surgical removal of a testicle	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care	Limitations An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and or family. Inpatient benefits and family counseling are limited to a maximum of two hundred and forty (240) days per Benefit Period. Bereavement counseling is limited to the one (1) year period following the Member's death up to a maximum of three (3) sessions.	
	Facility/agency	90% of Allowed Benefit
	Bereavement counseling	90% of Allowed Benefit
	Family counseling	90% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient hospital or health care facility	Limitations Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
	90% of Allowed Benefit	50% of Allowed Benefit
Skilled Nursing Facility	Limitations Hospital Pre-Certification and Review is required. Skilled Nursing Facility benefits are available only if admission to Skilled Nursing Facility occurs within fourteen (14) days from the date of discharge from a hospital confinement of no less than three (3) days duration. Skilled Nursing Facility services are limited to sixty (60) days per Benefit Period combined with Inpatient Rehabilitative Services.	
	No Deductible required 90% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	90% of Allowed Benefit	70% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other out-of-network related services
Cleft lip or cleft palate, or both		
Oral surgery		
Facility	Benefits are available to the same extent as benefits provided for other surgical services.	
Outpatient professional practitioner	Benefits are available to the same extent as benefits provided for other surgical services.	
Office	Benefits are available to the same extent as benefits provided for other surgical services.	
Otological, audiological and speech/language treatment		
Hospital	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Outpatient professional practitioner	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Office	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care		
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other outpatient care and medical supplies.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	80% of Allowed Benefit	70% of Allowed Benefit
Hair prosthesis	Limitation Benefits are limited to \$500 per Benefit Period.	
	80% of Allowed Benefit	70% of Allowed Benefit
Medical foods and nutritional substances	80% of Allowed Benefit	70% of Allowed Benefit
Medical Supplies	80% of Allowed Benefit	70% of Allowed Benefit
Orthotic Devices, Prosthetic Devices	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mental health and substance use disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient Health Care Provider Services	Limitations Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services	Benefits for outpatient care are available, including: <ul style="list-style-type: none"> • Partial hospitalization; • methadone maintenance treatment; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy. 	
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests and X-Rays		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	
Office	80% of Allowed Benefit	70% of Allowed Benefit
Other diagnostic services		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	Limitations Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services. Hospital Pre-Certification and Review is not applicable to admissions for cornea and kidney transplants.	
Organ and tissue transplants and transplant-related services provided by a Blue Distinction Center	Covered Services starting the date of transplant(s) through 90th day after date of transplant: No Deductible required 100% of Allowed Benefit Thereafter, Benefits are available to the same extent as benefits provided for transplants performed by non-Blue Distinction Centers.	Not applicable
Organ and tissue transplants and transplant-related services provided by other providers (Non-Blue Distinction Centers)		
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel and lodging		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Outpatient hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office/home	80% of Allowed Benefit	70% of Allowed Benefit
Medical care and consultations at Perdue HealthWorks/Perdue Wellness Center		
Non-routine/non-preventive services	No Deductible required 100% of Allowed Benefit after \$15 Copay* *Copay applies to exam only.	Not applicable
Non-routine/non-preventive laboratory tests	No Deductible required 100% of Allowed Benefit after \$5 Copay	Not applicable
Preventive and wellness services and screenings	No Deductible required 100% of Allowed Benefit	Not applicable

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Ambulatory surgical facility services	90% of Allowed Benefit	70% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	
Surgical assistant	90% of Allowed Benefit	
Female elective sterilization	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other out-of-network related services
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	
Temporomandibular joint (TMJ) dysfunction	Limitations Treatment of Temporomandibular Joint (TMJ) dysfunction is limited to \$600 per lifetime.	
	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Administration of injectable Prescription Drugs	80% of Allowed Benefit	70% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	80% of Allowed Benefit	70% of Allowed Benefit
Allergenic extracts (sera)	80% of Allowed Benefit	70% of Allowed Benefit
Allergy testing	80% of Allowed Benefit	70% of Allowed Benefit
Chemotherapy		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Home Infusion Therapy	80% of Allowed Benefit	70% of Allowed Benefit
Inhalation therapy		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Radiation therapy		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Renal dialysis		
Hospital	80% of Allowed Benefit	
Outpatient professional practitioner	80% of Allowed Benefit	
Office	80% of Allowed Benefit	
Spinal manipulation	Limitations Spinal manipulation is limited to 25 days per Benefit Period.	
Office	80% of Allowed Benefit	70% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	Limitations An approved Plan of Treatment is required. Outpatient private duty nursing is limited to 20 days per Benefit Period. No inpatient Private Duty Nursing services are available.	
Facility/agency	90% of Allowed Benefit	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drugs	Limitations Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: <ul style="list-style-type: none"> • injectable Prescription Drug contraceptives and contraceptive devices 	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy		
Office/home	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative Services		
Inpatient Rehabilitative Services	Limitations Hospital Pre-Certification and Review is required. Inpatient Rehabilitation Services are limited to sixty (60) days per Benefit Period combined with Skilled Nursing Facility.	
	No Deductible required 90% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Outpatient Rehabilitative Services		
Occupational Therapy	Limitations Occupational Therapy benefits are limited to 25 days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Physical Therapy	Limitations Physical Therapy benefits are limited to 25 days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Speech Therapy	Limitations Speech Therapy benefits are limited to 25 days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Cardiac Rehabilitation		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Pulmonary Rehabilitation		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Wellness services provided by the Group's Designated Wellness Services Provider	No Deductible required 100% of Allowed Benefit*	

* The Allowed Benefit is the Designated Wellness Provider's actual charge.

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

**TOTAL CARE AND COST IMPROVEMENT, PATIENT-CENTERED MEDICAL HOME, AND
DISEASE MANAGEMENT ADDENDUM**

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This Addendum is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. The effective date of coverage and termination date of coverage under this Addendum are the same as the effective date and termination date stated in the Group's Administrative Services Agreement for the benefits described herein.

The provisions of this Addendum do not apply to Members for whom Medicare is the primary carrier.

SECTION 1. DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage, for purposes of this Addendum, the underlined terms, below, when capitalized, have the following meaning:

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

Care Coordination Team, for purposes of the Patient-Centered Medical Home Program, means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, for purposes of the Patient-Centered Medical Home Program, means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses and includes case management through the Substance Abuse and Behavioral Health Program.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: Patient-Centered Medical Home Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Abuse and Behavioral Health Program, or other community-based programs outlined in this section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Health Care Provider, for purposes of the Patient-Centered Medical Home Program, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this section.

Qualifying Individual, for purposes of the Patient-Centered Medical Home Program, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Qualified Member means a Member who:

1. Is accepted by CareFirst into one or more of the TCCI Programs described in this section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.
2. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.
3. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.
4. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

Specialist, for purposes of the Patient-Centered Medical Home Program, means a licensed health care provider who is certified or trained in a specified field of medicine.

Substance Abuse and Behavioral Health Program, is a TCCI Program that includes a range of services that deal with the mental health of a Member (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program category are substance abuse services as well as psycho-social services.

SECTION 2. DESCRIPTION OF COVERED SERVICES

Benefits are available for:

A. TCCI Covered Services and Cost Sharing Waiver

1. Qualified Members are eligible for a waiver of certain cost sharing responsibility for benefits provided under this section when:
 - a. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or
 - b. At CareFirst's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in a CCM Program or a CCC Program.
2. Qualified Members participating in a CCM Program or a CCC Program as set forth in paragraph A.1.a., are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:
 - a. Assessment of Qualified Member/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;
 - b. Education of Qualified Member/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;
 - c. Assistance in navigating and coordinating health care services and understanding benefits;

- d. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;
 - e. Assistance in arranging consultation(s) with Specialists;
 - f. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;
 - g. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.
 - h. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.
 - i. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.
3. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under paragraph A.1.a., or, pursuant to CareFirst initiation under paragraph A.1.b., are eligible for benefits under following TCCI Program elements:
- a. Comprehensive Medication Review (CMR). Benefits will be provided for a Pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.
 - b. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.
 - c. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.
 - d. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any Home Health Care visit limits stated in the Schedule of Benefits.
 - e. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.
 - f. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.
 - g. Substance Abuse and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and substance use disorder services, including behavioral health treatment benefits.
4. Qualified Member Cost Sharing Responsibilities.
- a. Any applicable cost-sharing responsibilities under this section (TCCI Covered Services and Cost Sharing Waiver) will be waived for (i) TCCI Program services

provided by a Designated Provider, and (ii) in-network services provided to Qualified Members in an active plan of care.

- b. Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits (ii) services provided in an inpatient institution or facility, or (iii) any services provided in a hospital.
- c. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:
 - 1) If the Qualified Member has funded his/her HSA account during the calendar year, then the Qualified Member will be responsible for any associated costs for services under this section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.
 - 2) If the Qualified Member has not funded his/her HSA account during the calendar year, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in paragraph A.4.a.

5. Termination

- a. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this section will be terminated under the following circumstances:
 - 1) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner.
 - 2) When confirmed by the Qualified Member's treating physician or nurse practitioner if the TCCI Program(s) benefits are provided to Qualified Members not in an active plan of care.
 - 3) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.
 - 4) The Qualified Member's coverage under the Evidence of Coverage is terminated.
- b. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under paragraph A.5.a.3), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this section.

- c. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the effective date of the termination of the waiver.

B. PCMH Covered Services

Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.
2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.
3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;
4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

C. Disease Management Covered Services

1. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.
2. Disease Management Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.
 - b. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

SECTION 3. SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies, or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment, as stated below.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Total Care and Cost Improvement Program	Limitations Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for TCCI Program or Patient-Centered Medical Home Program.	
Services provided pursuant to a plan of care	No Deductible required 100% of Allowed Benefit	No benefit
TCCI Program elements		
Patient-Centered Medical Home Program	Limitations Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst approved Health Care Provider who has elected to participate in the CareFirst Patient-Centered Medical Home Program.	
	No Deductible required 100% of Allowed Benefit	No benefit
Disease Management		
Disease Management services	No Deductible required 100% of Allowed Benefit	No benefit
Disease Management Coaching services	No Deductible required 100% of Allowed Benefit	No benefit

This Addendum is issued to be attached to the Evidence of Coverage.

CLAIMS PROCEDURES

Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group Health Plan has deemed itself subject to ERISA.

- A. DEFINITIONS**
- B. CLAIMS PROCEDURES**
- C. CLAIMS PROCEDURES COMPLIANCE**
- D. CLAIM FOR BENEFITS**
- E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)**
- F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**
- G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS**
- H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL**
- I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**
- J. NOTICE**
- K. EXTERNAL REVIEW PROCESS**

A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,

2. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Claimant's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

Group Health Plan means an employee welfare benefit Plan within the meaning of section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of section 733(a) of the Act.

Health Care Professional means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

Independent Review Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the claims administrator under this Group Contract.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Claimant's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeal of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Claimants.

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Rescissions are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.

C. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Claimant or authorized representative.

The above shall apply only in the case of a failure that:

- a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and
 - b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.
2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

D. CLAIM FOR BENEFITS

A Claim for Benefits is a request for a Plan benefit or benefits made by a Claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

1. In general. Except as provided in paragraph E.2, if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.
2. The Claimant shall be notified of the determination in accordance with the following, as appropriate.
 - a. Expedited Notification of benefit determinations involving urgent care. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
 - 1) Receipt of the specified information, or
 - 2) The end of the period afforded the Claimant to provide the specified additional information.
 - b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
 - 1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

- 2) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and Appeal shall be governed by paragraphs H.2.a, H.2.b, or H.2.c, herein as appropriate.
 - 3) Continued coverage will be provided pending the outcome of an Appeal.
- c. Other claims. In the case of a claim that is not an urgent care claim or a concurrent care decision the Claimant shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.
- 1) Pre-Service Claims. In the case of a Pre-Service Claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein.
 - 2) Post-Service Claims. In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.
- d. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.c above due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the

extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

3. Deemed exhaustion of internal claims and Appeals processes. If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:
 - a. The specific reason or reasons for the adverse determination;
 - b. Reference to the specific Plan provisions on which the determination is based;
 - c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
 - d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the Act following an Adverse Benefit Determination on review;

- e. In the case of an Adverse Benefit Determination:
 - 1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
 - 2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.
- 2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in paragraph E.2.a herein, provided that a written or electronic Notification in accordance with paragraph F.1 of this section is furnished to the Claimant not later than three (3) days after the oral Notification.

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

- 1. To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within 180 days of the Adverse Benefit Determination.
- 2.
 - a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
 - b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;
 - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- 3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;
 - b. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to

whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - d. Health Care Professionals engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and
 - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.
4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
- a. The Plan or the Plan's Designee shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and
 - b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.
5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided below and in paragraph H.2, a Claimant shall be Notified in accordance with paragraph I. herein of the benefit determination on review within a

reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.

2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.
 - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.
 - b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
 - c. Post-service claims. In the case of a Post-Service Claim, except as provided below, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
3. Calculating time periods. For purposes of paragraph H. herein, the period of time within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph I.1 herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs I.3, I.4, and I.5 herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;
4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and
5.
 - a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
 - b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and or your State insurance regulatory agency.

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan's Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:
 - a. The Plan or the Plan's Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
 - b. The Plan or the Plan's Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan's Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.
 - c. The Plan or the Plan's Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

- d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.
 - e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.
2. Form and manner of Notice.
- a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.
 - b. Requirements
 - 1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;
 - 2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and
 - 3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.
 - c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

- 1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.
- 2. In addition to the State information provided below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

Maryland Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(877) 261-8807
<http://www.oag.state.md.us/Consumer/HEAU.htm>

3. Scope

- a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.
- b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:
 - 1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and
 - 2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

- a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:
 - 1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - 2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the

requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);

- 3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and
- 4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

- c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

- 1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- 2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- 3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within

one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.

- 4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.
- 5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (a) The Claimant's medical records;
 - (b) The attending health care professional's recommendation;
 - (c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;
 - (d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- 6) The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the

External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.

- 7) The assigned IRO's decision Notice will contain:
 - (a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;
 - (f) A statement that judicial review may be available to the Claimant; and
 - (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - 8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
- d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
5. Expedited External Review for self-insured Group Health Plans
- a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:
- 1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;

- 2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
- b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.
- c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.
- The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.
- d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.
6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

APPENDIX A

The Prescription Drug Program

Enrollment in the Plan automatically includes coverage under the Prescription Drug Program. This program is administered separately from your medical benefits under the Plan by Express Scripts.

How the Prescription Drug Program Works

The Prescription Drug Program offers you the following three ways to fill prescriptions:

- At a local participating pharmacy;
- At a local nonparticipating pharmacy; or
- By home delivery (mail order), phone or online.

After three fills at a retail pharmacy for a drug you use on an ongoing basis, often referred to as maintenance drugs, you will be asked to make a choice to continue filling at retail or move to the home delivery (mail order) service. Regardless of your choice of pharmacy, you should present the ID card you received at enrollment along with your prescription. This may allow the pharmacy to help you file a claim for benefits.

Your cost varies depending on the type of drug and how you choose to fill your prescriptions.

Retail Drug Card – Participating Pharmacy – You Pay a Set Fee for Each Prescription

A participating pharmacy is a pharmacy that is an Express Scripts participating retail pharmacy under the Prescription Drug Program. The pharmacist will charge you the appropriate copayment for your prescription (see “Copayments” for details). That is the only amount you pay.

Your copayment at a participating pharmacy for up to a 30-day supply is:

- \$6 for generic drugs (Tier One);
- \$30 for preferred brand name drugs (Tier Two); and
- Non-preferred brand name drugs (Tier Three) are not covered, except as provided in “How Prescription Drugs Are Classified,” below.

A separate copayment applies for each additional up-to-30-day supply you purchase. For example, if you purchase a 90-day supply from a participating retail pharmacy, your copayment will be \$18 for a generic drug (Tier One) and \$90 for a preferred brand name drug (Tier Two).

The Prescription Drug Program has a “generics preferred policy” to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

After two (2) fills of a prescription at a participating pharmacy, you will be asked to make a choice to continue filling at retail or move to the Plan’s home delivery (mail order) service.

To find a participating pharmacy near you:

- Call Express Scripts toll-free at 1-800-211-8497; or
- Access Express Scripts online at www.express-scripts.com.

Ask your local pharmacy if it is an Express Scripts participating pharmacy.

How Prescription Drugs Are Classified

A **generic drug** is a medication chemically equivalent to a brand name drug on which the patent has expired. Generic drugs are in Tier One. Generic versions of brand name drugs contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs. See the section “Generics Preferred” for details about how the Plan pays benefits for generic drugs.

A brand name drug is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. A **preferred brand name drug** is a drug that is included on the Plan’s drug formulary list as a prescription drug product preferred by the Prescription Drug Program for dispensing. Preferred brand name drugs do not have a generic equivalent and are in Tier Two. Also known as “formulary drugs,” these medicines have been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and have been selected by Express Scripts to be included in the formulary based on their proven clinical and cost effectiveness.

Non-preferred drugs (Tier Three) are not included on the Plan’s drug formulary list, and generally they are not covered by the Prescription Drug Program. These drugs usually have an alternative therapeutically-equivalent drug available. In the rare event that your medical condition requires a non-preferred drug, and if you have tried and failed with two similar drugs on the formulary list, your doctor may contact Express Scripts to ask to have a non-preferred drug authorized for you. If your request is approved, benefits for the non-preferred drug will be at the Tier Two level.

Nonparticipating Pharmacy

You must pay the full cost for your prescription when you use a nonparticipating pharmacy.

Home Delivery Service – Filling Prescriptions By Mail – You Pay a Set Fee for up to a 90-day Supply

The Express Scripts mail service is a great way to fill prescriptions for medication you take on a long-term or ongoing basis. You may receive up to a 90-day supply for one copayment. Home delivery (mail order) may be your best option for prescription drugs that you take on a regular *basis for conditions such as asthma, high blood pressure, and high cholesterol*. Your prescriptions are filled and double-checked by Express Scripts’ licensed pharmacists and sent to you in a plain, weather-resistant pouch for privacy and protection.

You may get up to a 90-day supply of your medications—which may mean fewer refills and fewer visits to your pharmacy, as well as lower costs. Once you begin using the home delivery, you can order refills online, by phone, or by mail.

To begin using the home delivery, follow these steps:

- Ask your physician to write a prescription for up to a 90-day supply of your medicine, plus refills for up to one year (if appropriate). You should also ask for a second prescription for an initial 30-day supply to fill locally.
- Complete a Home Delivery Order Form, available online at www.express-scripts.com, or by calling 1-800-211-8497.
- Put your prescription, payment and completed order form in the home delivery envelope and mail it to Express Scripts.

Your prescription drug will be mailed to your home in 10 to 14 business days from the day you mailed the prescription to Express Scripts, with no charge for standard U.S. Postal Service delivery. You may request overnight delivery for an additional charge. You may also indicate if you want your medicine in a child-resistant or non-child-resistant bottle.

A pharmacist is available 24 hours a day to answer questions about your medicines.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

Your copayment for each prescription filled through home delivery for up to a 90-day supply is:

- \$12 for generic drugs (Tier One);
- \$50 for preferred brand name drugs (Tier Two); and
- Non-preferred brand name drugs (Tier Three) are not covered, except as provided in “How Prescription Drugs Are Classified,” above.

The Prescription Drug Program has a “generics preferred policy” to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Amount of Copayment or Coinsurance

The amount of your copayment or coinsurance depends on where your prescription is filled and whether it is filled with a Tier One, Tier Two or Tier Three drug. The following chart shows the copayment and/or coinsurance amounts.

At a participating pharmacy	<ul style="list-style-type: none">• \$6 for a 30-day supply of a generic drug (Tier One)• \$30 for a 30-day supply of a preferred brand name drug** (Tier Two)• Non-preferred brand name drugs (Tier Three) are not covered, except as provided in “How Prescription Drugs Are Classified,” above.• After two (2) fills of a prescription at a participating pharmacy, you will be asked to make a choice to continue filling at retail or move to the Plan’s home delivery service.
One copayment applies for each 30-day supply.	
There is a 90-day limit. (You will not be permitted to purchase more than a 90-day supply at a time.)	

At a non-participating pharmacy	<ul style="list-style-type: none"> • 100% (no Plan benefit)*
By mail, phone or online There is a 90-day limit. (You will not be permitted to purchase more than a 90-day supply at a time.)	<ul style="list-style-type: none"> • \$12 for up to a 90-day supply of a generic drug (Tier One), \$6 for up to a 90-day supply of a generic drug (Tier One) used to treat diabetes • \$50 for up to a 90-day supply of a preferred brand name drug** (Tier Two), \$30 for up to a 90-day supply of a preferred brand name drug (Tier Two) used to treat diabetes • Non-preferred brand name drugs (Tier Three) are not covered, except as provided in “How Prescription Drugs Are Classified,” above.
* The costs you pay do not count towards your deductible and out-of-pocket maximum.	
** If a generic substitute is available for a brand name drug that is prescribed and filled, you’ll need to pay the applicable generic copayment plus an additional charge.	

Drugs Requiring Prior Authorization

Some drugs require prior authorization. This means that Express Scripts will need to make sure these prescriptions meet the Plan’s conditions for coverage. (You can contact Express Scripts for a current list of drugs that require prior authorization.) If a drug you take requires prior authorization, your physician will need to contact Express Scripts for a clinical review. If your prescription is authorized, you will pay your copay. If the prescription is not approved for coverage, and you and your physician decide that you should still take the prescribed drug that was not authorized, you will pay the full cost of the medication.

To determine if your medication requires prior authorization, **your physician** (not you) should call the Express Scripts’ prior authorization line at 1-800-753-2851. The best way to avoid inconvenience is to have your physician call the prior authorization line before you go to the pharmacy or send for your prescription by mail. The prior authorization line is not for patient use. You cannot obtain prior authorization by calling this line yourself.

Dispensing Limits and Other Limits

To promote safety and appropriate and cost-effective use of prescription drugs, the Prescription Drug Program includes a “drug quantity management” feature. For certain prescription drugs, it places a limit on the quantity that can be dispensed at one time. Quantity dispensing limits are based on:

- The manufacturer’s recommended dosage and duration of therapy;
- Common usage for episodic or intermittent treatment;
- FDA-approved recommendations and/or clinical studies; and
- Guidelines of the Plan.

In addition to the above limits, the Prescription Drug Program limits the number of days for which a prescription can be filled. For each prescription filled, you can obtain a supply of up to 90 days.

The Prescription Drug Program provides benefits for fertility drugs, **up to a lifetime maximum benefit of \$10,000**. Benefits are not otherwise available for the treatment of Infertility.

Step Therapy Program

“Step therapy” is a series of programs designed to manage appropriate use of “tried and true” first-line drugs before using newer, less tested, and more expensive second-line drugs. Step therapy requires patients to receive a trial of one or more first-line drugs before prescriptions are covered for second-line drugs when medically appropriate. Patients currently taking a second-line drug will be able to continue therapy without interruption.

To promote the use of cost-effective first-line therapy, the Prescription Drug Program applies step therapy for certain drug categories, including but not limited to the following:

- Arthritis and pain medicines (COX-2s) such as Celebrex;
- Ulcer/reflux medicines such as generic Prilosec and generic Prevacid;
- Blood pressure or heart medicines (angiotensin receptor antagonists) such as Diovan and Benicar;
- Asthma, allergic rhinitis, and chronic bronchitis medicines such as Singulair;
- High cholesterol medicines (HMGs) such as Crestor and Vytorin; and
- Allergy medicines (non-sedating antihistamines (NSAs) such as fexofenadine).

A physician can override the step therapy program **when appropriate for medical reasons** by submitting a prior authorization request to Express Scripts by calling 1-800-753-2851.

Express Scripts Specialty Pharmacy

Accredo is Express Scripts’ full-service specialty pharmacy. It serves a wide range of patients, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and post-transplant needs. **All specialty drugs must be filled through Accredo** (other than medications administered through your treating physician), though you are allowed one initial fill of a specialty drug at a retail pharmacy.

Accredo offers a complete range of services and specialty drugs, many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medicine.

To begin receiving your specialty drugs through Accredo, call them toll-free at 1-800-803-2523.

Accredo services include:

- Patient counseling – convenient access to pharmacists and nurses who are specialty medicine experts;
- Patient education – education material;
- Convenient delivery – coordinated delivery to your home, your doctor’s office, or other approved location;
- Refill reminders; and
- Language assistance – interpreting services for non-English-speaking patients.

Prescription Drug Program Exclusions

The following are not covered under the Prescription Drug Program:

- Drugs and medicines that ordinarily can be obtained without a prescription (i.e. over-the-counter medications);
- Anabolic steroids (Winstrol, Anadrol-50, Oxandrin, Deca-Durabolin);
- Appetite suppressants and other weight loss products;
- Contraceptive devices/implants, diaphragms, IUDs or Norplant;
- Durable medical equipment (except for nebulizer/supplies, breathing devices-peak meters and breathing supplies) ;
- Injectable serums, vaccines or allergens;
- Legend hair growth products (e.g., Propecia);
- Legend hair removal products (e.g., Vaniqa);
- Legend vitamins (except prenatal vitamins, b-12 injection, vitamins with fluoride);
- Prescriptions that exceed the 90-day limit;
- Renova;
- Replacement prescriptions; and
- Any drug or chemical not approved by the Food and Drug Administration in the dosage prescribed, for the reason prescribed, on in the form prescribed. This includes, but it not limited to, non-FDA approved compounded drugs.

Note that if you participate in the HealthCare Flexible Spending Account, the portion you pay for over-the-counter medications may be eligible for reimbursement through your health care FSA if you submit a written prescription from your doctor for the medication.

For certain other prescription drug exclusions, please consult the section of this Booklet entitled “Expenses Not Covered.”

Filing a Prescription Drug Claim

You do not need to file a claim if you use a participating pharmacy. You only need to complete a special order envelope when you use home delivery. On a refill, it is even easier; you can just call or go online and provide your credit card number.

If you use a nonparticipating pharmacy, you need to pay the full cost for the prescription and file a claim for reimbursement.

Information When You Need It at www.express-scripts.com

Go online to www.express-scripts.com for 24-hour access to information regarding the Prescription Drug Program. Use this website to:

- Find out about your copayment amounts;
- Verify coverage for eligible dependents;
- View or print a list of drugs included in the Plan's formulary;
- Locate participating retail pharmacies near you;
- Review your 12-month prescription history;
- Order refills; and
- Check the status of your mail order prescription.

Register now to access www.express-scripts.com. Once you are registered, you will have the information you need about your prescription drug benefits right at your fingertips.

Perdue Farms Inc. – ESS20, Inc.

BluePreferred Option

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance make the Group Contract's terms and provisions binding on CareFirst and the Group.

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part. Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Individuals enrolled in the Plan are also covered by the Prescription Drug Program described in Appendix A. Appendix A is not part of the Evidence of Coverage or the Group Contract and is not administered by CareFirst—it is administered by Express Scripts. It is being provided together with this Evidence of Coverage solely for the convenience of the participants. As described more fully in the Evidence of Coverage, both covered medical expenses and covered prescription drug expenses count toward the Plan's deductibles and out-of-pocket maximums.

Group Name: Perdue Farms Inc. – ESS20 BluePreferred

Account
Number(s): 67088

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. **Preferred Health Care Providers:** For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.
2. **Non-Preferred Health Care Providers:**
 - a. **Non-Preferred health care practitioner:** For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or Carefirst's established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.
 - b. **Non-Preferred hospital or health care facility:** For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or Carefirst's established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.
 - c. **Non-Preferred Emergency Services Health Care Provider:** CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:
 - 1) The Allowed Benefit stated in paragraphs 2.a., or 2.b.
 - 2) The amount negotiated with Preferred Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Preferred Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

- 3) The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Preferred Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.
- 4) The amount that would be paid under Medicare (part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

Adverse Decision means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: January 1st through December 31st.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of Eligible Members.

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member whereby CareFirst and the Member share in the payment for Covered Services.

Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that has contracted with CareFirst.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hooyer/stair lifts, ramps, shower/bath bench, items available without a prescription).

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one Copay.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

Deductible means the dollar amount of Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him/herself.

Dependent means a Member other than the Subscriber (e.g., the eligible spouse, etc.), meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained the Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment; or
6. Satisfaction of any combination of the above factors.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

Designated Wellness Services Provider means a third party service provider contracted by Group to provide specific wellness services to Members. For purposes of this Evidence of Coverage, the Group's Designated Wellness Services Provider is a Non-Preferred Provider. Services provided by the Group's Designated Wellness Services Provider are as defined by the Group. For description of such services please contact the Group directly.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage means this agreement, which includes the acceptance, riders and amendments, if any, between the Group and CareFirst (also referred to as the Group Contract).

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA means the U.S. Food and Drug Administration.

Group means the Subscriber's employer/Plan Sponsor or other organization to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the Group Contract includes any riders and/or amendments attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Habilitative mean health care services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

Infusion Therapy means treatment that places therapeutic agents into the vein, including intravenous feeding.

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

Limiting Age means the maximum age to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Director means a board certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. Not primarily for the convenience of a patient or Health Care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

Member means an individual who meets all applicable eligibility requirements, is enrolled either as a Subscriber or Dependent, and for whom payment has been received by CareFirst.

Non-Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that does not contract with CareFirst.

Non-Preferred Health Care Provider means any Health Care Provider that is not a Preferred Provider.

Occupational Therapy means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

Paid Claims means the amount paid by CareFirst for Covered Services. Inter-Plan Arrangements Fees and Compensation are also included in Paid Claims. Other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator may also be included in Paid Claims.

Physical Therapy means the short-term treatment described below that can be expected to result in an improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan of Treatment means the plan written and given to CareFirst by the attending Health Care Provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The contracted Preferred Provider has the obligation of referring Members within the network. Preferred Provider relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another.

A listing of Preferred Providers may be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any Health Care Provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means:

1. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription."
2. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
3. Prescription Drugs do not include:
 - a. Compounded bulk powders that contain ingredients that:
 - 1) Do not have FDA approval for the route of administration being compounded, or
 - 2) Have no clinical evidence demonstrating safety and efficacy, or
 - 3) Do not require a prescription to be dispensed.
 - b. Compounded drugs that are available as a similar commercially available Prescription Drug unless:
 - 1) There is no commercially available bio-equivalent Prescription Drug; or
 - 2) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Private Duty Nursing means Skilled Nursing Care that is not rendered in a hospital/Skilled Nursing Facility.

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Service Area means CareFirst's Service Area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members.

Skilled Nursing Care, depending on the place of service/benefit, means:

Home Health Care	Outpatient Private Duty Nursing	Inpatient hospital/facility /Skilled Nursing Facility
Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).		Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member’s safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility).		
Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider.	Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.	
Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.		
Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.		

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition, absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist means a physician who is certified or trained in a specified field of medicine.

Specialty Drug means Prescription Drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns – requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy means the treatment of communication impairment and swallowing disorders. Speech Therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

Substance Use Disorder means:

1. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or
2. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family except for Benefits for Members Entitled to Medicare (Medicare Complementary) in which case Type of Coverage means Individual coverage. Additional categories of coverage do not apply to Benefits for Members Entitled to Medicare. Each Medicare-eligible person, including a Medicare-eligible Dependent, will be enrolled in an Individual Type of Coverage category under the Group Contract.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

A. **Requirements for Coverage**

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

1. The individual elects coverage;
2. The individual is entitled to Medicare, if Medicare Complementary coverage applicable;
3. The Group accepts the individual's election and notifies CareFirst; and
4. Payments are made on behalf of the Member by the Group.

B. **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section B.1., and as stated in the Termination of Coverage section of the Evidence of Coverage.

When an Employee enrolls a Dependent in the Plan, the enrollment constitutes a representation by the Employee that the individual meets the definition of a Dependent and is eligible for the Plan, and that the Employee will provide evidence of eligibility on request. The enrollment also constitutes an acknowledgement by the Employee that the Plan is relying on the Employee's representation of eligibility in accepting the enrollment of the Dependent. If the Employee fails to provide evidence of eligibility when requested, that failure is evidence of fraud and material misrepresentation and the Plan may terminate coverage for the individual, which termination may be retroactive to the date as of which the individual first become ineligible.

1. **Open Enrollment Period**

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

- a. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
- b. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

2. **Newly Eligible Subscriber**

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period or a special enrollment period.

3. **Special Enrollment Periods**

Special enrollment is allowed for certain individuals in conjunction with: (1) a loss of other coverage, (2) the acquisition of certain Dependent beneficiaries or (3) losing eligibility for Medicaid or CHIP coverage, or gaining eligibility for premium assistance under Medicaid or CHIP. The Subscriber or individual seeking special enrollment must provide notice within the time period described in the Eligibility Schedule. Enrollment will be effective as stated in the Eligibility Schedule.

These special enrollment periods are not the same as Medicare special enrollment periods.

If only the Subscriber is eligible under this Evidence of Coverage and dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

If retirees are eligible for coverage under this Evidence of Coverage, references to an employee shall be construed to include a retiree, except for references made in the context of special enrollment for certain individuals who lose coverage, as special enrollment for certain individuals who lose coverage is not applicable to retirees.

a. Special enrollment for certain individuals who lose coverage:

- 1) CareFirst will permit current employees and dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
- 2) Individuals eligible for special enrollment.
 - a) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:
 - (1) The employee and the Dependents are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
 - (3) The employee satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - b) When Dependent loses coverage. A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:
 - (1) The Dependent and the employee are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

- (3) The Dependent satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - (4) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph B.3.a.2)b), or the employee satisfies the criteria of paragraph B.3.a.2)a) of this section.
- 3) Conditions for special enrollment.
- a) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph B.3.a.3)a) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:
 - (1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
 - (2) In the case of coverage offered through a health maintenance organization, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) ;
 - (3) In the case of coverage offered through a health maintenance organization, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual; and
 - (4) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

- b) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.
 - c) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph B.3.a.3)a) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.
 - d) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)
- 4) Applying for special enrollment and effective date of coverage. The Group or CareFirst will allow an employee a period of at least thirty (30) days after an event described above to request enrollment (for the employee or the employee's Dependent).
- a) Coverage will begin no later than the first day of the first (1st) calendar month beginning after the date the Group or CareFirst receives the request for special enrollment.

- b. Special enrollment with respect to certain Dependent beneficiaries:
- 1) Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2), of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
 - 2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph B.3.a.2)a), b), c), d), e), or f) of this section.
 - a) Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption.
 - b) Spouse of a participant only. An individual is described in this paragraph if either:
 - (1) The individual becomes the spouse of a participant; or
 - (2) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.
 - c) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:
 - (1) The employee and the spouse become married; or
 - (2) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.
 - d) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.
 - e) Current employee and a new Dependent. A current employee and an individual who is a dependent of the employee, are described in this paragraph if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.
 - f) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

- c. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

CareFirst will permit an employee or Dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

- 1) Termination of Medicaid or CHIP coverage. The employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.
- 2) Eligibility for employment assistance under Medicaid or CHIP. The employee or Dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

MEDICAL CHILD SUPPORT ORDERS

A. Definitions

1. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
 - a. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
 - b. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
2. Qualified Medical Support Order (QMSO) means a MCSO issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended.

B Eligibility and Termination

1. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage the child will not be enrolled until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.

2. Enrollment for such a child will not be denied because the child:
 - a. Was born out of wedlock.
 - b. Is not claimed as a dependent on the Subscriber's federal tax return.
 - c. Does not reside with the Subscriber.
 - d. Is covered under any Medical Assistance or Medicaid program.
3. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
 - a. The MCSO/QMSO is no longer in effect;
 - b. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or

- c. If coverage is provided under an employer sponsored health plan;
 - 1) The employer has eliminated family member's coverage for all employees;
or
 - 2) The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable state or federal law, the child will continue in this post-employment coverage.

C. **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

- 1. Send the non-insuring custodial parent ID cards, claims forms, the applicable evidence of coverage or member contract and any information needed to obtain benefits;
- 2. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
- 3. Provide benefits directly to:
 - a. The non-insuring parent;
 - b. The Health Care Provider of the Covered Services; or
 - c. The appropriate child support enforcement agency of any state or the District of Columbia.

TERMINATION OF COVERAGE

A. **Disenrollment of Individual Members**

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons:

1. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.
2. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.
3. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.
4. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.
5. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.
6. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

B. **Death of a Subscriber**

If Dependent coverage is available, in the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

C. **Effect of Termination**

No benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

D. **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

A. Continuation of Eligibility upon Loss of Group Coverage

1. **Federal Continuation of Coverage under COBRA**

If the Group health benefit Plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit Plan may be possible. The employer offering this Group health benefit Plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the Plan Administrator.

2. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

COORDINATION OF BENEFITS; SUBROGATION

A. Coordination of Benefits

1. Applicability

- a. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
- b. If this COB provision applies, the Order of Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
 - 1) Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; and
 - 2) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is explained in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

2. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Evidence of Coverage.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

- a. An individually underwritten and issued, guaranteed renewable, specified disease policy;
- b. An intensive care policy, which does not provide benefits on an expense incurred basis;
- c. Coverage regulated by a motor vehicle reparation law;
- d. The first one-hundred dollars (\$100) per day of a hospital indemnity contract;
- e. An elementary and/or secondary school insurance program sponsored by a school or school system; or
- f. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

- a. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- b. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- c. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

3. **Order of Benefit Determination Rules**

- a. **General**
When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - 1) The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
 - 2) Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

b. **Rules**

This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

- 1) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a) Secondary to the Plan covering the person as a dependent; and
 - b) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

- 2) Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:
 - a) For a dependent child whose parents are married or are living together:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - (2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.
 - b) For a dependent child whose parents are separated, divorced, or are not living together:
 - (1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in 3.b.2)a) above also shall apply if: i) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child.

- (2) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:
 - (a) The Plan of the parent with custody of the child;
 - (b) The Plan of the spouse of the parent with the custody of the child;
 - (c) The Plan of the parent not having custody of the child; and then
 - (d) The Plan of the spouse of the parent who does not have custody of the child.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in a) and b) of this paragraph as if those individuals were parents of the child.
- 3) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 4) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:
 - a) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);
 - b) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 5) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

4. **Effect on the Benefits of this CareFirst Plan**

a. **When this Section Applies**

This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

b. **Reduction in this CareFirst Plan's Benefits**

When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

5. **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.

6. **Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

7. **Right of Recovery**

If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

B. **Employer or Governmental Benefits**

Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

- 1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
- 2. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

C. Subrogation

1. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:
 - a. Caused by an act or omission of a third party; or
 - b. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or
 - c. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose. CareFirst will not subrogate a recovery made under Personal Injury Protection policy benefits.
2. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Evidence of Coverage, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid in benefits up to the amount received from or on behalf of the third party. CareFirst will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.
3. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.
4. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

For purposes of this provision, "made whole" means that the Member fully recovers all of their damages.

5. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Evidence of Coverage. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.
6. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in the “Choosing a Provider” subsection below. Other factors that may affect payment are found in Referrals, COB, Subrogation, the Inter-Plan Arrangements Disclosure, Inter-Plan Programs Ancillary Services, Exclusions, and Utilization Management Requirements.

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

- a. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider contracts with CareFirst or not relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.
- b. CareFirst makes payment for Covered Services but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Preferred Health Care Providers

- a. If a Member chooses a Preferred Health Care Provider, the cost to the Member is lower than if the Member chooses a Non-Preferred Health Care Provider. Throughout the Schedule of Benefits, payments are listed as either “in-network” (for a Preferred Health Care Provider) or “out-of-network” (for a Non-Preferred Health Care Provider).

If a Preferred Health Care Provider refers a Member to a Non-Preferred Health Care Provider, CareFirst will pay the in-network benefit, but the Member will still be responsible for the difference between CareFirst’s payment and the Non-Preferred Health Care Provider’s charge.

- b. Claims will be submitted directly to CareFirst by the Preferred Health Care Provider.
- c. CareFirst will pay benefits directly to the Preferred Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.
- d. The Member is responsible for any applicable Deductible and Coinsurance or Copayment, as stated in the Schedule of Benefits.

3. **Non-Preferred Health Care Providers**
 Except as otherwise authorized by CareFirst, if a Member chooses a Non-Preferred Health Care Provider, Covered Services may be eligible for reduced benefits. When Covered Services are provided by a Non-Preferred Health Care Provider, out-of-network benefits apply.
 - a. Claims may be submitted directly to CareFirst or its designee by the Non-Preferred Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
 - b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Preferred Health Care Provider, at the discretion of CareFirst.
 - c. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the appropriate department of an appropriate State (as designated in the order or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.
 - d. Non-Preferred Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Preferred Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Member is responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.
4. **Ambulance Services Providers**
 - a. For purposes of calculating the Member payment for Ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide	
If a Member receives Covered Services from:	Member liability:
Preferred Ambulance Services Provider	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Ambulance Services Provider	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Ambulance Services Provider's actual charge.

- b. If a Member receives services from a Preferred Provider, the cost to the Member is lower than if the Member receives services from a Non-Preferred Provider.
- C. **Notice of Claim**
 A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

D. Claim Forms

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

E. Proofs of Loss

In order to receive benefits for services rendered by a Health Care Provider who does **not** contract with CareFirst, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

1. Claims for medical benefits must be submitted within fifteen (15) months following the dates services were rendered.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the member, not later than one year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

F. Time of Payment of Claims

Benefits payable under this Evidence of Coverage will be paid not more than thirty (30) days after receipt of written proof of loss.

G. Claim Payments Made in Error

If CareFirst makes a claim payment to or on behalf of a Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

H. Assignment of Benefits

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Preferred Health Care Provider rendering Covered Services. A Member may not assign his or her right to bring a lawsuit under ERISA against Perdue, the Plan, the Plan Administrator, or CareFirst

I. Evidence of Coverage

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable. Only one statement will be issued for each family unit.

J. Notices

Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail or by first class mail to the most recent address for the Member in CareFirst's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

K. **Privacy Statement**

CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

L. **Prescription Drug Rebate Sharing**

CareFirst may be eligible for rebates from Prescription drug manufacturers upon negotiating directly with manufacturers.

CareFirst and the Plan Sponsor, as such is defined in the Administrative Services Agreement, agree to the extent to which any such rebates are shared.

REFERRALS

Referral Requirements

- A. Written referrals are not required.
- B. Referral to a Specialist or Non-Physician Specialist
1. Non-Physician Specialist means a Health Care Provider who is not a physician who is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any state or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.
 2. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and
 - a. CareFirst does not contract with a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
 - b. CareFirst cannot provide reasonable access to a contracted specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
 3. For purposes of calculating any Member payment, CareFirst will treat the services provided by the Specialist or Non-Physician Specialist as if the services were provided by a Preferred Health Care Provider.
- C. Referrals Quick Reference

While written referrals are not required, Covered Services with a referral will be available as follows:

For Covered Services:			
If a Member sees a:	With referral:	Without referral:	Member liability:
Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.		No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.	Covered Services will be paid at the out-of-network level of benefits if out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted for Covered Services: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Health Provider's actual charge.

This Referrals Quick Reference guide is subject to the terms stated in the Referral to a Specialist or Non-Physician Specialist section, above.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

Most Prescription Drugs classified as Specialty Drugs require prior authorization; prior authorization applies to Specialty Drugs covered under the medical portion of this Evidence of Coverage (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings). Specialty Drugs are defined in the Definitions section of this Evidence of Coverage. Preferred Health Care Providers will obtain prior authorization from CareFirst on behalf of the Member. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization/a Plan of Treatment. Failure to obtain prior authorization may result in denial of the claim.

A. Plan of Treatment

Certain outpatient services indicated throughout this Evidence of Coverage require CareFirst's approval of a Plan of Treatment before benefits for Covered Services are provided; a penalty may apply if such approval is not obtained.

1. A health care practitioner must complete and submit a Plan of Treatment.
2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.
3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.
4. Within the Service Area, a Preferred Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Preferred Health Care Provider or a Non-Preferred Health Care Provider.
5. Services for which CareFirst must approve a Plan of Treatment:
 - a. Controlled Clinical Trial Patient Cost coverage

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
 - b. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

c. Home Health Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late (forty-eight (48) hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

d. Hospice Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing hospice care, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

e. Private Duty Nursing

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

B. Hospital Pre-Certification and Review

A Preferred Health Care Provider, in and out of the Service Area, will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Preferred Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

- a. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.
- b. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.
- c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.
- d. Pre-operative days will not be approved for procedures unless Medically Necessary.
- e. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.
- f. CareFirst's payment will be based on the inpatient days approved by the reviewer.
- g. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.

- h. Hospital Pre-Certification and Review is not applicable to maternity admissions, and admissions for cornea and kidney transplants.
2. Non-Emergency (Elective) Admissions
- a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.
 - b. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.
 - c. CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - d. For Out-of-Network Covered Services:
 - 1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50% ;
 - b) The Member is responsible for this penalty.
3. Emergency (Non-Elective) Admissions
- a. The Member, the Health Care Provider or another person acting on behalf of the Member must notify the reviewer within twenty-four (24) hours following the Member's admission, or as soon thereafter as reasonably possible.

The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify the reviewer of the emergency admission within twenty-four (24) hours if the Member's medical condition prevented the hospital from determining:

 - 1) The Member's insurance status; and
 - 2) The reviewer's emergency admission notification requirements.
 - b. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:
 - 1) During the first twenty-four (24) hours the Member is in an inpatient facility; or
 - 2) Until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a Member has been admitted and shall state the reasons for the admission.

- c. The reviewer will make all initial determinations on whether to approve a non-elective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

For non-elective admissions for which the reviewer receives notice but does not approve inpatient benefits, CareFirst will notify the hospital attending Health Care Provider that inpatient benefits will not be paid as of the date of notification.

- 1) A Member will have to pay:
 - a) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.
 - b) Non-Preferred Health Care Providers if a non-elective admission results in payment denial.
- 2) A Member will not have to pay Preferred Providers:
 - a) If the Member is admitted and the admission is not Medically Necessary;
 - b) If a non-elective admission results in payment denial.

- d. For Out-of-Network Covered Services:

- 1) CareFirst will not provide benefits for a non-elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
- 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the non-elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

- 4. Continued Stay Review
The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.
- 5. Discharge Planning
The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.

6. Program Monitoring
 - a. The Member's medical record will be reviewed by the reviewer.
 - b. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.
 - c. During and after discharge, the reviewer may review the medical records to:
 - 1) Verify that the services are covered under the Evidence of Coverage;
 - 2) Ensure that the Health Care Provider is substantially following the Plan of Treatment.
7. Notice and Appeals
 - a. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.
 - b. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.
 - 1) If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.
 - 2) For instructions on how to appeal an Adverse Decision, refer to the Claims Procedures of this Evidence of Coverage.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services

Overview

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan. The Inter-Plan Programs are described generally below.

When a Member receives care outside of CareFirst’s service area, it will be received from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. CareFirst explains below how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst’s service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst’s service area and care received outside the geographic area CareFirst serves is stated in the Definitions.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when a Member receives Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When a Member receives Covered Services outside CareFirst’s service area and the claim is processed through the BlueCard Program, the amount a Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount a Member pays for Covered Services under this arrangement will be calculated based on the negotiated price/lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to a Member, the Member will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, a Member will incur no liability, other than any related Member cost sharing.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside CareFirst's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount a Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, a Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

E. **Blue Cross Blue Shield Global Core Program**

If a Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), the Member may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit Member claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **Members must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Members pay for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submission, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs);
2. Medical Devices and Supplies; and
3. Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care).

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider or a Health Care Provider who contracts with the local Blue Cross and/or Blue Shield Licensee in that geographic area as stated in the Inter-Plan Arrangements Disclosure.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: <ul style="list-style-type: none"> • Shipped to; or • Purchased at a retail store. 	
Specialty Prescription Drugs	Ordering/prescribing physician is located.	

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE (Medicare Complementary)

The provisions in this section apply to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in this Evidence of Coverage. Benefits that are covered by Medicare are subject to the provisions in this section.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures; however, the Utilization Management Requirements of this Evidence of Coverage do not apply to persons for whom Medicare is the primary carrier.

Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Providers contracted with CareFirst, all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

This coverage is not Medicare supplemental coverage. This coverage provides benefits for some charges and services not covered by Medicare. It is not designed to fill the "gaps" of Medicare.

Covered Services under Medicare Complementary are the same as under the Description of Covered Services. Only the manner of payment is different:

- A. **Coverage Secondary to Medicare**
Except where prohibited by law, CareFirst benefits are secondary to Medicare.
- B. **Medicare as Primary**
 - 1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare:
 - a. For any Health Care Provider who accepts Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge.
 - b. For any Health Care Provider who does not accept Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the limitation set by Medicare.
 - 2. **For a Member who Elects Medicare Part B:** CareFirst will coordinate as described above and pay benefits based on Medicare's payment. For example, after meeting the Part B deductible, Medicare pays 80% of the Medicare approved amount for most doctor services; the basis for CareFirst's payment is the remaining 20% of the Medicare approved amount (the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge/limitation set by Medicare).

a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming:	
Part B deductible has been met; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%; and Medicare approved charge does not exceed limitation set by Medicare, if applicable	
Medicare approved amount	\$ 1,000.00
Multiplied by 80% equals Medicare payment	\$ 800.00
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

3. **For a Member who Does not Elect Part B:** CareFirst will reduce its payment to “carve-out” or reject the 80% coinsurance Medicare would have paid if the Member had elected Part B.

- a. If the amount Medicare would have paid is available, CareFirst will coordinate as described above, “carving-out” or rejecting the amount Medicare would have paid. CareFirst will base its reduced Coinsurance payment on the amount Medicare would have paid if the Member had elected Part B.
- b. If the amount Medicare would have paid is not available, CareFirst will base its Coinsurance payment on 20% of the Allowed Benefit. The 80% reduction to the Allowed Benefit represents the amount that Medicare theoretically would have paid if the Member had elected Part B.

c. Numerical Examples for a Member who Does not Elect Part B:

- 1) In the first numeric example below, CareFirst's Allowed Benefit is assumed to be the same as the Medicare approved amount in the above example for a Member who elects Medicare Part B. In this example, CareFirst's payment does not differ; however, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available;	
CareFirst Deductible, if applicable, has been met;	
CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 1,000.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

- 2) In the second numeric example below, CareFirst's Allowed Benefit is assumed to differ from the Medicare approved amount in the above example for a Member who elects Medicare Part B. Again, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available;	
CareFirst Deductible, if applicable, has been met;	
CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 500.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 100.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 100.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 80.00

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists other features that affect Member coverage, including, if applicable, the Deductible, Out-of-Pocket Maximum, and specific benefit limitations. It is also important to review the section entitled “Exclusions.”

PREVENTIVE AND WELLNESS SERVICES

A. Covered Services:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
 - a. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.
 - b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.
 - c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
2. If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.
3. CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

AMBULANCE SERVICES

A. Covered Services

1. Medically Necessary air transportation, surface, and ground ambulance services, as determined by CareFirst.
 - a. Foreign Transportation: If the Member requires professional medical care for an injury or illness while traveling outside the United States, CareFirst or its authorized agent will cover the reasonable and necessary costs to transport the Member to a location where more appropriate medical care is available.

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Is approved by:
 - a. The National Institutes of Health (NIH) or a Cooperative Group.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - 1) To be comparable to the system of peer review of studies and investigations used by the NIH, and
 - 2) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - h. The FDA in the form of an investigational new drug application.
 - i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Evidence of Coverage for non-Investigational treatments.

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:
 - a. Treatment provided for a life-threatening condition; or,
 - b. Prevention, early detection, and treatment studies on cancer.
2. Coverage will be provided only if:
 - a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer; or,
 - b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;
 - c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,
 - e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.
3. Coverage is provided for the Patient Cost, including Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

DIABETES EQUIPMENT

Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

DIABETES SUPPLIES

Coverage will be provided for all Medically Necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

DIABETES SELF-MANAGEMENT TRAINING

1. Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
2. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

1. With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the Member.
2. Medically Necessary air transportation, surface, and ground ambulance services, as determined by CareFirst.
3. Urgent Care services.

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:
 - a. If the Member is:
 - 1) Seven years of age or younger, or developmentally disabled;
 - 2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and
 - 3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - b. Or, if the Member is:
 - 1) Seventeen years of age or younger;
 - 2) An extremely uncooperative, fearful, or uncommunicative individual;
 - 3) An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - 4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - c. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - d. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - 1) A fully accredited specialist in pediatric dentistry;
 - 2) A fully accredited specialist in oral and maxillofacial surgery; and
 - 3) A dentist who has been granted hospital privileges.
 - e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

HOME HEALTH CARE

A. Definitions

Home Health Care means the continued care and treatment of a Member by a Health Care Provider in the home if:

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and
2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

Home Health Care Visits means:

1. Each visit by a member of a Home Health Care team is considered one Home Health Care Visit; and
2. Up to four (4) hours of Home Health Care service is considered one Home Health Care visit.

B. Covered Services

1. Home Health Care, as defined above.
2. Home Visits Following Childbirth, including any services required by the attending Health Care Provider:
 - a. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or ninety-six (96) hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;
 - b. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):
 - 1) One home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge;
 - 2) An additional home visit following childbirth if prescribed by the attending Health Care Provider.
 - c. An attending Health Care Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Health Care Provider, attending the Member or newborn Dependent child(ren).
 - d. Home visits following childbirth must be rendered, as follows:
 - 1) In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
 - 2) By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

3. Home Visits Following the Surgical Removal of a Testicle
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - 1) One home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and
 - 2) An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

C. Limitations

1. The Member must be confined to “home” due to a medical condition. “Home” cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.
2. The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. “Skilled Nursing Care,” for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.
4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).
5. See additional limitations in the Schedule of Benefits.

HOSPICE CARE

A. Definitions

Caregiver means a person who is not a Health Care Provider who lives with or is the primary caregiver of the Member in the home. The Caregiver can be a relative by blood, marriage or adoption or a friend of the Member, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

1. Inpatient hospice facility services;
2. Part-time nursing care by or supervised by a registered graduate nurse;
3. Counseling, including dietary counseling, for the Member;
4. Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the Member;
5. Medical care by the attending physician;
6. Other Medically Necessary health care services at CareFirst's discretion.

Additionally, hospice care benefits are available for a Member's family (family is the spouse, parents, siblings, grandparents, child(ren), and/or Caregiver) for periodic family counseling before the Member's death, and bereavement counseling.

A Member, or representative of the Member, can petition CareFirst to review the Member's case and authorize an extension of coverage. CareFirst reserves the right to extend the hospice care eligibility period for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care, if it determines that the patient's prognosis and continued need for services are consistent with a program of hospice care. Additional "reserve" benefits (up to 45 days) apply if the Member exceeds: the Hospice Eligibility Period and/or the inpatient benefit limit.

INFERTILITY SERVICES

A. Definitions

Infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.

B. Covered Services

1. Benefits are available for the diagnosis of Infertility excluding artificial insemination/intrauterine insemination and in vitro fertilization.
2. Under the Prescription Drug Coverage (see APPENDIX A), benefits are available for fertility drugs, up to a lifetime maximum of \$10,000. Benefits are not otherwise available for the treatment of Infertility.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(ambulatory services; hospitalization; laboratory services)

A. Covered Services

1. Inpatient/outpatient medical care and consultations.

Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Health Care Provider and a Member. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

2. Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

3. Surgery, as follows:

a. Oral surgery, limited to:

- 1) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity not solely involving teeth.
- 2) Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

- 1) The injury did not arise while or as a result of biting or chewing; and
- 2) Treatment is commenced within twelve (12) months of the injury or, if due to the nature of the injury treatment could not begin within twelve (12) months of the injury, treatment began within twelve (12) months of the earliest date that it would be medically appropriate to begin such treatment.

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

- b. Medically Necessary surgical procedures, as determined by CareFirst.

If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

- 1) If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.
- 2) If the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

- c. Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are (i) Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention, or (ii) described in the following section, entitled "Mastectomy Related Services.

- 4. Inpatient/outpatient assistant if the surgery requires surgical assistance as determined by CareFirst.
- 5. Inpatient/outpatient anesthesia services by a Health Care Provider other than the operating surgeon.
- 6. Inpatient/outpatient chemotherapy.
- 7. Home Infusion Therapy.
- 8. Inpatient/outpatient radiation therapy.
- 9. Inpatient/outpatient renal dialysis.
- 10. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
- 11. Administration of injectable Prescription Drugs by a Health Care Provider.
- 12. Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), allergy testing.
- 13. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.

14. Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from oral surgery, and otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.
15. Elective sterilization.
16. Skilled Nursing Facility services.
17. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
18. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
2. Breast prostheses prescribed by a physician for a Member who has undergone a mastectomy and has not had breast reconstruction;
3. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member;
4. Inpatient hospital services for a minimum of forty-eight (48) hours following a mastectomy as a result of breast cancer. A Member may request a shorter length of stay if the Member decides, in consultation with the attending physician, that less time is needed for recovery.
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - 1) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
 - 2) An additional home visit if prescribed by the Member's attending physician.
 - b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician.

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services including:
 - a. Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:
 - 1) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support supplies and consultation; and
 - 2) Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B” or provided in the comprehensive guidelines for women’s preventive health supported by the Health Resources and Services Administration.
 - b. Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not identified in section A.1.a. above, and Ancillary Services provided during those visits. Benefits include Medically Necessary laboratory diagnostic tests and services not identified in section A.1.b. above, including, but not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
 - c. Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event;
 - d. Medically Necessary services for the normal newborn (an infant born at approximately forty (40) weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
 - e. Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;
 - f. Circumcision.
2. Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - a. A minimum of:
 - 1) forty-eight (48) hours following an uncomplicated vaginal delivery;
 - 2) ninety-six (96) hours following an uncomplicated cesarean section.
 - b. Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.

3. Coverage for victims of rape or incest.
4. Birthing classes: one course per pregnancy at a CareFirst approved facility.
5. Birthing centers.
6. Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
7. Benefits are available for comprehensive lactation support and counseling, by a Health Care Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

1. Is primarily and customarily used to serve a medical purpose;
2. Is not useful to a person in the absence of illness or injury;
3. Is ordered or prescribed by a physician or other qualified practitioner;
4. Is consistent with the diagnosis;
5. Is appropriate for use in the home;
6. Is reusable; and
7. Can withstand repeated use.

Medical Device means Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

1. Are primarily and customarily used to serve a medical purpose;
2. Are not useful to a person in the absence of illness or injury;
3. Are ordered or prescribed by a physician or other qualified practitioner;
4. Are consistent with the diagnosis;
5. Are appropriate for use in the home;
6. Cannot withstand repeated use; and
7. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
4. May be purely passive support or may make use of spring devices;
5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a Health Care Provider; and
5. Is removable and attached externally to the body.

B. Covered Services

1. **Durable Medical Equipment**

Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

2. **Hair Prosthesis**

Benefits are available for a hair prosthesis

3. **Medical foods and nutritional substances**

Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

4. **Medical Supplies**

Benefits are available for Medical Supplies as such supplies are defined above.

5. **Orthotic Devices, Prosthetic Devices**

Benefits include:

- a. Supplies and accessories necessary for effective functioning of the Orthotic or Prosthetic Device;
- b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
- c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

6. **Repairs.** Benefits for the repair, maintenance or replacement of an Orthotic or Prosthetic Device require authorization or approval by CareFirst. Benefits are limited to:
- a. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
 - b. Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.
 - c. Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

**MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES,
INCLUDING BEHAVIORAL HEALTH TREATMENT**

Inpatient/outpatient mental health and Substance Use Disorder services, including behavioral health treatment.

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

Donor Services consist of services covered under the Evidence of Coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Recipient/Donor Services

When Member is a:	Benefits are available for:
Recipient	Benefits are available for both the Member recipient and the non-Member donor. Donor benefits are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services.

Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/ Investigational as determined by CareFirst.
2. Donor Services, limited to the extent stated above.
3. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.
4. Immunosuppressant maintenance drugs when prescribed for a covered transplant.
5. Organ transplant procurement benefits for the recipient, as follows:
 - a. Health services and supplies used by the surgical team to remove the donor organ.
 - b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.
 - c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
6. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;
2. Conform to all laws that apply to organ transplants; and
3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;
2. Diagnosis;
3. Type of surgery; and
4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

Benefits are available for Medically Necessary outpatient Private Duty Nursing, as determined by CareFirst. Benefits are not provided for Private Duty Nursing rendered in a hospital.

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits are available through Express Scripts for Pharmacy-dispensed Prescription Drugs. Please see Appendix A at the end of this Evidence of Coverage for a description of the Prescription Drug Program.	Benefits are available, and limited to, Prescription Drugs dispensed in the office of a Health Care Provider. Contraceptives: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.

PROFESSIONAL NUTRITIONAL COUNSELING/MEDICAL NUTRITION THERAPY

A. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

B. Covered Services

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

REHABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**

Benefits are available for inpatient Rehabilitative Services.

2. **Outpatient Rehabilitative Services**

Benefits are available for the following outpatient Rehabilitative Services:

a. Occupational Therapy;

b. Physical Therapy; and

c. Speech Therapy.

3. **Cardiac Rehabilitation**

Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide Cardiac Rehabilitation.

Benefits will not be provided for maintenance programs.

4. **Pulmonary Rehabilitation**

Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide pulmonary rehabilitation.

Benefits will not be provided for maintenance programs.

5. **Visual Therapy**

Benefits are available for outpatient visual therapy.

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Preferred Health Care Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
 2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
 3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including: flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
 - Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
 - Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).
 - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
 - All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the Member, unless otherwise a Covered Service.

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.
- Any procedure or treatment designed to alter an individual’s physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to health education classes and self-help programs, except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary rehabilitation programs and services provided by the Group’s Designated Wellness Services Provider.
- Medical or surgical treatment for obesity, unless otherwise specified in the Description of Covered Services.
- Medical or surgical treatment or regimen for reducing or controlling weight for morbid obesity.

These exclusions do not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.

- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomies and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.
- Non-medical Health Care Provider services, including, but not limited to:
 1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
 2. Administrative fees charged by a Health Care Provider to a Member to retain the Health Care Provider’s medical practice services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.
- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider’s charges and billed for by them.

- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).
- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.
- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.

- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.
- Immunizations solely for foreign travel.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in the Description of Covered Services.
- Hearing care except as otherwise stated.
- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.
- Work Hardening Programs. Work Hardening Programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

Ambulance Services

- Except Medically Necessary ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

Emergency Services

- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

General anesthesia and associated hospital or ambulatory surgical facility services for dental care

- Dental care for which general anesthesia is provided.

Home Health Care

- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.
- Respite care.

Infertility Services

- Medical or surgical treatment for Infertility, except as stated in the Description of Covered Services.

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.
- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.
- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).
- Acupuncture.
- Inpatient or outpatient orthodontic expenses for the treatment of cleft lip and/or cleft palate.
- Inpatient Private Duty Nursing.
- Procedures to reverse sterilization.
- Surgical removal of impacted teeth.
- Elective Abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother or expenses are incurred to treat medical complications due to the abortion or the pregnancy is the result of rape or incest.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Medical Supplies, except as stated in the Description of Covered Services, or any riders attached to this Evidence of Coverage.
- Orthotic Devices and Prosthetic Devices, except as stated in the Description of Covered Services.
- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

Mental health and Substance Use Disorder services, including behavioral health treatment

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses Incurred for the location of a suitable donor; e.g., search of a population or mass screening.

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services or Appendix A.

Rehabilitative Services

- Services delivered through early intervention and school services.
- Applied Behavioral Analysis services.

ELIGIBILITY SCHEDULE

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group.	
Spouse	Coverage for a Dependent spouse is available.	
Domestic Partner	Coverage Domestic Partners is not available.	
Dependent children	Coverage for Dependent children, excluding children of a Domestic Partner, is available.	Limiting Age Up to age 26
Unmarried incapacitated Dependent children	<p>A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:</p> <ol style="list-style-type: none"> 1. The Dependent child is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty (30) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated. 	Limiting Age Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber	<p>A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.</p> <p>A Subscriber who is not enrolled when the Group receives a QMSO is eligible for coverage effective on the date specified in the MCSO.</p>
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	<p>The employee must notify the Group, and the Group must notify CareFirst no later than thirty (30) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.</p>
Special enrollment for certain dependent beneficiaries	<p>The employee must notify the Group, and the Group must notify CareFirst during the thirty (30) day special enrollment period beginning, as follows:</p> <p>In the case of marriage: the date of marriage.</p> <p>In the case of a newly born child: the date of birth.</p> <p>In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent (or, if Dependent coverage is not generally available at the time of the adoption or the placement for adoption, a period of thirty (30) days after Dependent coverage is made generally available by the Group).</p>
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).</p> <p>A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.</p>

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the date eligibility ceases as determined by the Group.
Dependent child	A Dependent child will remain covered until the birthday when the Dependent child reaches the Limiting Age for a Dependent child .
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the date eligibility ceases as determined by the Group.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.
Subscriber changes the Type of Coverage to an Individual or other non-family contract (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Coverage will terminate on the date the Subscriber changes the Type of Coverage to an Individual or other non-family contract.
Death of a Subscriber	Coverage of any Dependents will terminate on the date determined by the Group.

SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced. See Utilization Management Requirements for these rules.

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

DEDUCTIBLE			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$1,200	\$2,400	\$2,400	\$4,800
Applicable to all in-network benefits, except as stated in the Description of Covered Services.		Applicable to all out-of-network benefits, except as stated in the Description of Covered Services.	
In-Network and Out-of-Network			
The in-network and out-of-network Deductible will be a combined amount.			
The Deductible is calculated based on the Allowed Benefit of Covered Services.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Deductible, then for the remainder of the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Deductible and the Family Deductible apply. If the Family Deductible has not been met for the Benefit Period, then a Member must meet the Individual Deductible before CareFirst will pay the benefit amounts specified in the Schedule of Benefits for that Member. If the Family Deductible has been met for the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits for all covered family Members.			
The following amounts are included/excluded from the Deductible:		Included	Excluded
Amounts in excess of the Allowed Benefit		No	Yes
Pharmacy-dispensed Prescription Drugs as provided in Appendix A		Yes	No

OUT-OF-POCKET MAXIMUM			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$6,000	\$12,000	\$12,000	\$24,000
In-Network and Out-of-Network			
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for the remainder of the Benefit Period.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum apply. If a covered family Member has met the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for that Member for the remainder of the Benefit Period. If a covered family Member has not met the Individual Out-of-Pocket Maximum, but the family as a whole has met the Family Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for all covered family Members for the remainder of the Benefit Period.			
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.			
The following amounts are included/excluded from the Out-of-Pocket Maximum:	Included	Excluded	
Amounts in excess of the Allowed Benefit	No	Yes	
Coinsurance (Member's share)	Yes	No	
Deductible	Yes	No	
Pharmacy-dispensed Prescription Drugs as provided in Appendix A	Yes	No	

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are not Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Adult preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Chlamydia screening	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Colorectal cancer screening		
Hepatitis C screening		
Human papillomavirus screening		
Mammography/breast cancer screening		

Covered Services	CareFirst Payment		
	In-Network	Out-of-Network	
Preventive and wellness services			
Osteoporosis prevention			
Prostate cancer screening			
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.		
Primary purpose of the office visit is not the delivery of preventive and wellness services			
Office visit and, if not billed separately, preventive and wellness services	80% of Allowed Benefit	70% of Allowed Benefit	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services	Limitations Ambulance services are limited, as follows: <ul style="list-style-type: none"> Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance. 	
Ambulance Services	80% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Limitations Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes equipment	80% of Allowed Benefit	70% of Allowed Benefit
Diabetes supplies	80% of Allowed Benefit	70% of Allowed Benefit
Diabetes self-management training	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services		
Emergency Services in a hospital emergency room/department		
Hospital emergency room/department and ancillary services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	80% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Outpatient professional practitioner(s) in hospital emergency room/department	80% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Member admitted as inpatient	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Hospital emergency room/department services for any condition that is not an Emergency Medical Condition	Please see “Medical care and consultations (illness visits)” table below.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office	80% of Allowed Benefit	70% of Allowed Benefit
Urgent Care center	80% of Allowed Benefit	50% of Allowed Benefit
Dental services related to accidental injury or trauma	Limitations Treatment must be provided within twelve (12) months from the date of the injury.	
	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
General anesthesia and associated hospital or ambulatory surgical facility services for dental care	Limitations An approved Plan of Treatment may be required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	Limitations An approved Plan of Treatment is required for Home Health Care. Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS) provided under the Total Care and Cost Improvement Program. Hospital/home health agency: Twenty (20) Home Health Care visits per Benefit Period.	
	Hospital/home health agency	80% of Allowed Benefit
	Home visits following childbirth	70% of Allowed Benefit
	Home visits following mastectomy	80% of Allowed Benefit
	Home visits following the surgical removal of a testicle	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care	<p>Limitations An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and or family.</p> <p>Benefits for Hospice care services are limited to a maximum two-hundred and forty (240) days per Benefit Period.</p> <p>Benefits for bereavement counseling are limited to three (3) visits within one year of the family member's death.</p>	
Facility/agency	80% of Allowed Benefit	80% of Allowed Benefit
Bereavement counseling	80% of Allowed Benefit	80% of Allowed Benefit
Family counseling	80% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient hospital or health care facility	Limitations Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
Facility	80% of Allowed Benefit	50% of Allowed Benefit
Inpatient practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Skilled Nursing Facility	Limitations Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 60 days per Benefit Period combined with Inpatient rehabilitation. Admission must be within fourteen (14) days of a hospital confinement of at least three (3) days.	
	No Deductible required 80% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	80% of Allowed Benefit	50% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Cleft lip or cleft palate, or both		
Oral surgery		
Facility	Benefits are available to the same extent as benefits provided for other surgical services.	
Outpatient professional practitioner	Benefits are available to the same extent as benefits provided for other surgical services.	
Office	Benefits are available to the same extent as benefits provided for other surgical services.	
Otological, audiological and speech/language treatment		
Hospital	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Outpatient professional practitioner	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Office	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	No prior authorization required for maternity admissions.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other outpatient care and medical supplies.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mastectomy-Related Services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	80% of Allowed Benefit	70% of Allowed Benefit
Hair prosthesis (Cancer diagnosis only)	Limitations Benefits for hair prosthesis are limited to \$500 per Benefit Period.	
	80% of Allowed Benefit	70% of Allowed Benefit
Medical foods and nutritional substances	80% of Allowed Benefit	70% of Allowed Benefit
Medical Supplies	80% of Allowed Benefit	70% of Allowed Benefit
Orthotic Devices, Prosthetic Devices	80% of Allowed Benefit	70% of Allowed Benefit
Treatment of temporomandibular joint dysfunction	Limitations Benefits for the treatment of temporomandibular joint dysfunction are limited to \$600 lifetime maximum.	
	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mental health and Substance Use Disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient Health Care Provider Services	Limitations Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services	Benefits for outpatient care are available, including: <ul style="list-style-type: none"> • Partial hospitalization; • methadone maintenance treatment; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy. 	
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests and X-Rays		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	80% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Other diagnostic services		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	80% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	Limitations Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services.	
Organ and tissue transplants and Related Services performed and/or provided at a Blue Distinction Center (BDC)	Organ/tissue transplant and services provided by a BDC for the first ninety (90) days from the date of transplant: No Deductible required 100% of Allowed Benefit Services provided by a BDC ninety (90) days <u>after</u> date of transplant: Benefit are available to the same extent as benefits provided for other illnesses.	No benefit
Organ and tissue transplants and transplant-related services provided by other providers (Non-Blue Distinction Centers)		
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel and lodging		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Services provided in an hospital emergency room for non-Emergency Medical Conditions and illness visits		
Hospital emergency room/department facility services	50% of Allowed Benefit after \$100 Copay* *Copay waived if Member is admitted.	50% of Allowed Benefit after \$100 Copay* *Copay waived if Member is admitted.
Outpatient professional practitioner services provided in an hospital emergency room/department	50% of Allowed Benefit	50% of Allowed Benefit
Services provided in other places of service for non-Emergency Medical Conditions and illness visits		
Outpatient hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office/home	80% of Allowed Benefit	70% of Allowed Benefit
Medical care and consultations at Perdue HealthWorks/Perdue Wellness Center		
Non-routine/non-preventive services	No Deductible required 100% of Allowed Benefit after \$15 Copay* *Copay applies to exam only.	Not applicable
Non-routine/non-preventive laboratory tests	No Deductible required 100% of Allowed Benefit after \$5 Copay	Not applicable
Preventive and wellness services and screenings	No Deductible required 100% of Allowed Benefit	Not applicable
Urgent Care center	Benefits are available to the same extent as benefits provided for Emergency Services provided in an Urgent Care facility.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Ambulatory surgical facility services	80% of Allowed Benefit	70% of Allowed Benefit
Anesthesia	80% of Allowed Benefit	Paid same as in-network
Surgical assistant	80% of Allowed Benefit	Paid same as in-network
Female elective sterilization	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other out-of-network related services.
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Administration of injectable Prescription Drugs	80% of Allowed Benefit	70% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	80% of Allowed Benefit	70% of Allowed Benefit
Allergenic extracts (sera)	80% of Allowed Benefit	70% of Allowed Benefit
Allergy testing		
Outpatient Facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Chemotherapy		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Home Infusion Therapy	80% of Allowed Benefit	70% of Allowed Benefit
Inhalation therapy		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Radiation therapy		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Renal dialysis		
Hospital	80% of Allowed Benefit	Paid same as in-network
Outpatient professional practitioner	80% of Allowed Benefit	Paid same as in-network
Office	80% of Allowed Benefit	Paid same as in-network
Spinal manipulation	Limitations Spinal manipulation is limited to 25 days per Benefit Period.	
Office	80% of Allowed Benefit	70% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	Limitations An approved Plan of Treatment is required. Outpatient private duty nursing is limited to 20 days per Benefit Period. No inpatient Private Duty Nursing benefits are available.	
	80% of Allowed Benefit	Paid same as in-network

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drugs	Limitations Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: <ul style="list-style-type: none"> injectable Prescription Drug contraceptives and contraceptive devices 	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy		
Office/home	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative Services		
Inpatient Rehabilitative Services	Limitations Hospital Pre-Certification and Review is required. Inpatient facility rehabilitation is limited to sixty (60) days per Benefit Period, combined with Skilled Nursing Facility.	
	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient Rehabilitative Services		
Occupational Therapy	Limitations Benefits for Occupational Therapy are limited to 25 days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Physical Therapy	Limitations Benefits for Physical Therapy are limited to 25 days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Speech Therapy	Limitations Benefits for Speech Therapy are limited to 25 days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Cardiac Rehabilitation		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Pulmonary Rehabilitation		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Wellness services provided by the Group's Designated Wellness Services Provider	No Deductible required 100% of Allowed Benefit*	

* The Allowed Benefit is the Designated Wellness Services Provider's actual charge.

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

**TOTAL CARE AND COST IMPROVEMENT, PATIENT-CENTERED MEDICAL HOME,
ENHANCED MONITORING PROGRAM, EXPERT CONSULTATION PROGRAM, HEALTH
PROMOTION AND WELLNESS PROGRAM, AND DISEASE MANAGEMENT ADDENDUM**

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This Addendum is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. The effective date of coverage and termination date of coverage under this Addendum are the same as the effective date and termination date stated in the Group's Administrative Services Agreement for the benefits described herein.

The provisions of this Addendum do not apply to Members for whom Medicare is the primary carrier.

SECTION 1. DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage, for purposes of this Addendum, the underlined terms, below, when capitalized, have the following meaning:

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

Care Coordination Team, for purposes of the Patient-Centered Medical Home Program, means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, for purposes of the Patient-Centered Medical Home Program, means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses and includes case management through the Substance Use and Behavioral Health Program.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: Patient-Centered Medical Home Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Use and Behavioral Health Program, or other community-based programs outlined in this section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Enhanced Monitoring Program (EMP) means the CareFirst program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Expert Consultation Program (ECP) means the CareFirst Program for Members with a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

Health Promotion and Wellness Program means a coordinated program designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Health Care Provider, for purposes of the Patient-Centered Medical Home Program, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this section.

Qualifying Individual, for purposes of the Patient-Centered Medical Home Program, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Qualified Member means a Member who:

1. Is accepted by CareFirst into one or more of the TCCI Programs described in this section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.
2. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.
3. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.
4. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

Specialist, for purposes of the Patient-Centered Medical Home Program, means a licensed health care provider who is certified or trained in a specified field of medicine.

Substance Use and Behavioral Health Program, is a TCCI Program that includes a range of services that deal with the mental health of a Member (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program category are Substance Use services as well as psycho-social services.

Weight Loss Services means CareFirst approved services available to clinically obese Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion and Wellness Program.

Wellness Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Wellness Program.

SECTION 2. DESCRIPTION OF COVERED SERVICES

Benefits are available for:

A. TCCI Covered Services and Cost Sharing Waiver

1. Qualified Members are eligible for a waiver of certain cost sharing responsibility for benefits provided under this section when:
 - a. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or
 - b. At CareFirst's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in a CCM Program or a CCC Program.
2. Qualified Members participating in a CCM Program or a CCC Program as set forth in paragraph A.1.a., are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:
 - a. Assessment of Qualified Member/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;
 - b. Education of Qualified Member/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;
 - c. Assistance in navigating and coordinating health care services and understanding benefits;
 - d. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;
 - e. Assistance in arranging consultation(s) with Specialists;
 - f. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;
 - g. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.
 - h. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.
 - i. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

3. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under paragraph A.1.a., or, pursuant to CareFirst initiation under paragraph A.1.b., are eligible for benefits under following TCCI Program elements:
 - a. Comprehensive Medication Review (CMR). Benefits will be provided for a Pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.
 - b. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.
 - c. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.
 - d. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any Home Health Care visit limits stated in the Schedule of Benefits.
 - e. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.
 - f. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.
 - g. Substance Use and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and Substance Use Disorder services, including behavioral health treatment benefits.
4. Qualified Member Cost Sharing Responsibilities.
 - a. Any applicable cost-sharing responsibilities under this section (TCCI Covered Services and Cost Sharing Waiver) will be waived for (i) TCCI Program services provided by a Designated Provider, and (ii) in-network services provided to Qualified Members in an active plan of care.
 - b. Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits (ii) services provided in an inpatient institution or facility, or (iii) any services provided in a hospital.
 - c. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:
 - 1) If the Qualified Member has funded his/her HSA account during the calendar year, then the Qualified Member will be responsible for any associated costs for services under this section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

- 2) If the Qualified Member has not funded his/her HSA account during the calendar year, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in paragraph A.4.a.

5. Termination

- a. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this section will be terminated under the following circumstances:
 - 1) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner.
 - 2) When confirmed by the Qualified Member's treating physician or nurse practitioner if the TCCI Program(s) benefits are provided to Qualified Members not in an active plan of care.
 - 3) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.
 - 4) The Qualified Member's coverage under the Evidence of Coverage is terminated.
- b. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under paragraph A.5.a.3), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this section.
- c. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the effective date of the termination of the waiver.

B. PCMH Covered Services

Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.
2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.
3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;
4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

C. Enhanced Monitoring Program

Benefits for medical equipment and monitoring services will be provided to a Member, without an active plan of care, who qualifies under the EMP as determined by CareFirst.

D. Expert Consultation Program

Benefits for review of a Member's medical records by a team of specialists will be provided to a Member, without an active plan of care, who qualifies under the ECP as determined by CareFirst. The review of the Member's medical records will be done in accordance with the ECP.

E. Health Promotion and Wellness Covered Services

1. Health Assessments are available for all adult Members.
2. Benefits are available for Biometric Screening of Members, as defined above.
3. Lifestyle Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.
 - b. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).
4. Other Wellness Program benefits are available, which may include tobacco-cessation, well-being challenges, and financial well-being improvement programs.
5. Weight Loss Services are available to clinically obese Members, as follows:
 - a. A clinically obese Member is a Member whose Body Measurement Index (BMI) score is greater than thirty (30).
 - b. A dedicated, CareFirst approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.

- c. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

F. **Disease Management Covered Services**

- 1. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.
- 2. Disease Management Coaching Session services may be available as follows:
 - a. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.
 - b. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

SECTION 3. SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies, or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment, as stated below.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Total Care and Cost Improvement Program	Limitations Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for TCCI Program or Patient-Centered Medical Home Program.	
TCCI program services provided pursuant to a plan of care	No Deductible required 100% of Allowed Benefit	No benefit
TCCI Program elements		
TCCI program services provided without a plan of care: Enhanced Monitoring Program, Expert Consultation Program		
Patient-Centered Medical Home Program	Limitations Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst approved Health Care Provider who has elected to participate in the CareFirst Patient-Centered Medical Home Program.	
	No Deductible required 100% of Allowed Benefit	No benefit
Health Promotion and Wellness	Limitations Benefits for Weight Loss Services are only available to Members with a BMI score greater than thirty (30).	
Biometric Screening services	No Deductible required 100% of Allowed Benefit	No benefit
Wellness Coaching services		
Other Wellness Program services		
Weight Loss Programs		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Disease Management		
Disease Management services	No Deductible required 100% of Allowed Benefit	No benefit
Disease Management Coaching services	No Deductible required 100% of Allowed Benefit	No benefit

This Addendum is issued to be attached to the Evidence of Coverage.

CLAIMS PROCEDURES

Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group Health Plan has deemed itself subject to ERISA.

- A. DEFINITIONS**
- B. CLAIMS PROCEDURES**
- C. CLAIMS PROCEDURES COMPLIANCE**
- D. CLAIM FOR BENEFITS**
- E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)**
- F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**
- G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS**
- H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL**
- I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**
- J. NOTICE**
- K. EXTERNAL REVIEW PROCESS**

A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,
2. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Claimant's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

Group Health Plan means an employee welfare benefit Plan within the meaning of section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of section 733(a) of the Act.

Health Care Professional means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

Independent Review Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the claims administrator under this Group Contract.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Claimant's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeal of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Claimants.

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Rescissions are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.

C. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Claimant or authorized representative.

The above shall apply only in the case of a failure that:

- a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and
- b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

D. CLAIM FOR BENEFITS

A Claim for Benefits is a request for a Plan benefit or benefits made by a Claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

1. In general. Except as provided in paragraph E.2, if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.
2. The Claimant shall be notified of the determination in accordance with the following, as appropriate.
 - a. Expedited Notification of benefit determinations involving urgent care. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
 - 1) Receipt of the specified information, or
 - 2) The end of the period afforded the Claimant to provide the specified additional information.

- b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
- 1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
 - 2) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and Appeal shall be governed by paragraphs H.2.a, H.2.b, or H.2.c, herein as appropriate.
 - 3) Continued coverage will be provided pending the outcome of an Appeal.
- c. Other claims. In the case of a claim that is not an urgent care claim or a concurrent care decision the Claimant shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.
- 1) Pre-Service Claims. In the case of a Pre-Service Claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein.

- 2) Post-Service Claims. In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.
 - d. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.c above due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
3. Deemed exhaustion of internal claims and Appeals processes. If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:
 - a. The specific reason or reasons for the adverse determination;
 - b. Reference to the specific Plan provisions on which the determination is based;
 - c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
 - d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the Act following an Adverse Benefit Determination on review;
 - e. In the case of an Adverse Benefit Determination:
 - 1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
 - 2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
 - f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.
2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in paragraph E.2.a herein, provided that a written or electronic Notification in accordance with paragraph F.1 of this section is furnished to the Claimant not later than three (3) days after the oral Notification.

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

1. To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within 180 days of the Adverse Benefit Determination.
2.
 - a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
 - b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;
 - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;
 - b. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
 - c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - d. Health Care Professionals engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and
 - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and
 - b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.
5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided below and in paragraph H.2, a Claimant shall be Notified in accordance with paragraph I. herein of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.
2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.
 - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.
 - b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

- c. Post-service claims. In the case of a Post-Service Claim, except as provided below, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
3. Calculating time periods. For purposes of paragraph H. herein, the period of time within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph I.1 herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs I.3, I.4, and I.5 herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;
4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and
5.
 - a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
 - b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and/or your State insurance regulatory agency.

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan's Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:
 - a. The Plan or the Plan's Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
 - b. The Plan or the Plan's Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan's Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.
 - c. The Plan or the Plan's Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.
 - d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.
 - e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.
2. Form and manner of Notice.
 - a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.
 - b. Requirements
 - 1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;
 - 2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and

- 3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.
- c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.
2. If a Claimant is in need of assistance, they may contact the appropriate state agency as follows:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Maryland Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571

<http://www.marylandattorneygeneral.gov/Pages/CPD/heau>

Additionally, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

3. Scope

- a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.
- b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:
 - 1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and
 - 2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

- a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:
 - 1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - 2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);

- 3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and
- 4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

- c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

- 1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- 2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- 3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.

- 4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.
- 5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
- (a) The Claimant's medical records;
 - (b) The attending health care professional's recommendation;
 - (c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;
 - (d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- 6) The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.

- 7) The assigned IRO's decision Notice will contain:
 - (a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;
 - (f) A statement that judicial review may be available to the Claimant; and
 - (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- 8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
- d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
5. Expedited External Review for self-insured Group Health Plans
 - a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:
 - 1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;

- 2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
- b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.
- c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.
- The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.
- d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.
6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

APPENDIX A

The Prescription Drug Program

Enrollment in the Plan automatically includes coverage under the Prescription Drug Program. This program is administered separately from your medical benefits under the Plan by Express Scripts.

How the Prescription Drug Program Works

The Prescription Drug Program offers you the following two ways to fill prescriptions:

- At a local participating pharmacy;
- By home delivery (mail order), phone or online.

After three fills at a retail pharmacy for a drug you use on an ongoing basis, often referred to as maintenance drugs, you will be asked to make a choice to continue filling at retail or move to the home delivery (mail order) service. Regardless of your choice of pharmacy, you should present the ID card you received at enrollment along with your prescription. This may allow the pharmacy to help you file a claim for benefits.

Your cost varies depending on the type of drug and how you choose to fill your prescriptions.

Retail – Participating Pharmacy

If you fill your prescription at a retail pharmacy that is an Express Scripts participating pharmacy, the pharmacist will charge you the coinsurance amount for your prescription. However, your coinsurance will never be below or above specified amounts. (See "Amount of Coinsurance" below for details.)

The amount you pay at a retail participating pharmacy for up to a 30-day supply is:

- For generic non-specialty drugs—20%, subject to an \$8 minimum and a \$16 maximum;
- For generic specialty drugs—20%, subject to a \$16 minimum and a \$32 maximum;
- For preferred brand non-specialty drugs—20%, subject to a \$30 minimum and a \$60 maximum; and
- For preferred brand specialty drugs—30%, subject to a \$50 minimum and a \$100 maximum.

You will only be permitted one fill of a specialty drug at a retail pharmacy, and only for a 30-day supply. After that, you must use the Plan's home delivery (mail order) service.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

A separate copayment applies for each additional up-to-30-day supply you purchase. For example, if you purchase a 90-day supply from a participating retail pharmacy, your copayment will be \$30 for a generic non-specialty drug and \$90 for a preferred brand non-specialty drug.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

After three fills of a non-specialty prescription at a participating retail pharmacy, you will be asked to make a choice to continue filling at retail or move to the Plan's home delivery (mail order) service.

To find a participating retail pharmacy near you:

- Call Express Scripts toll-free at 1-800-211-8497;
- Access Express Scripts online at www.express-scripts.com; or
- Download the Express Scripts Mobile App.

Ask your local pharmacy if it is an Express Scripts participating pharmacy.

Retail – Nonparticipating Pharmacy

You must pay the full cost for your prescription when you use a nonparticipating pharmacy.

Express Scripts Home Delivery (Mail Order)

The Express Scripts mail service is a great way to fill prescriptions for medication you take on a long term or ongoing basis. You may receive up to a 90-day supply for one copayment. (See "Amount of Copayment or Coinsurance" below for details.)

Home delivery (mail order) may be your best option for prescription drugs that you take on a regular *basis for conditions such as asthma, high blood pressure, and high cholesterol*. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and sent to you in a plain, weather-resistant pouch for privacy and protection.

You may get up to a 90-day supply of your medications—which may mean fewer refills and fewer visits to your pharmacy, as well as lower costs. Once you begin using the home delivery, you can order refills online, by phone, through the mobile app or by mail.

You can choose between these easy options:

- Call Express Scripts at the toll-free number on the back of your member ID card and let Express Scripts do all the work. For most medications, Express Scripts will be able to contact your doctor for you and arrange for your first mail-order supply.
- Visit www.express-scripts.com/StartHD. After logging in, select “Transfer your retail prescriptions” to get started. The Express Scripts Pharmacy will contact your doctor for you to obtain a 90-day prescription.
- Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate). Then, ask your doctor to electronically send the prescription to the Express Scripts Pharmacy.

To transfer any remaining maintenance medication refills from a retail pharmacy to home delivery, log in or register at **Express-Scripts.com** and look for “Transfer to Home Delivery” on the home page. Select the medications you’d like to transfer, click “Add to Cart” and checkout. Express Scripts does the rest.

Orders are usually processed 48 hours from when Express Scripts gets them. Your medicine should be delivered in about 8 days (10-14 days if it's a new prescription). If Express Scripts needs to contact your doctor for information, delivery may take longer. You can check your order status by going online anytime. Your prescription drug will be mailed to your home at no charge for standard U.S. Postal Service delivery. You may request overnight delivery for an additional charge. You may also indicate if you want your medicine in a child-resistant or non-child-resistant bottle.

A pharmacist is available 24 hours a day to answer questions about your medicines.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy coinsurance will apply.

Your copayment for each prescription filled through home delivery is:

- For generic non-specialty drugs—20%, subject to an \$16 minimum and a \$32 maximum;
- For generic specialty drugs—20%, subject to a \$16 minimum and a \$32 maximum;
- For preferred brand non-specialty drugs—30%, subject to a \$50 minimum and a \$100 maximum; and
- For preferred brand specialty drugs—30%, subject to a \$50 minimum and a \$100 maximum.

Home delivery of a 90-day supply of insulin, syringes, and diabetic supplies, will be covered at the same rate as a retail 30-day supply.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Amount of Coinsurance

The amount of your copayment or coinsurance depends on where your prescription is filled, whether it is filled with a generic or brand drug, and whether it is for a specialty or non-specialty drug.

Type of Drug	In-Network Retail	Mail Order	Out-of-Network
Generic Non-Specialty	20% coinsurance, subject to \$8 minimum and \$16 maximum (30-day supply)	20% coinsurance, subject to \$16 minimum and \$32 maximum (90-day supply)	not covered
Generic Specialty	20% coinsurance, subject to \$16 minimum and \$32 maximum (30-day supply) (1 fill only)	20% coinsurance, subject to \$16 minimum and \$32 maximum (30-day supply)	not covered
Preferred Brand Non-Specialty	20% coinsurance, subject to \$30 minimum and \$60 maximum (30-day supply)	30% coinsurance, subject to \$50 minimum and \$100 maximum (90-day supply)	not covered
Preferred Brand Specialty	30% coinsurance, subject to \$50 minimum and \$100 maximum (30-day supply) (1 fill only)	20% coinsurance, subject to \$50 minimum and \$100 maximum (30-day supply)	not covered
Insulin, Syringes, and Diabetic Supplies	Retail coinsurance and limits apply (30-day supply)	Retail coinsurance and limits apply (30-day supply)	not covered

Your medical and prescription drug claims are combined when determining whether you have met the In-Network Out-of-Pocket Maximum. Once the In-Network Out-of-Pocket maximum amount is met, the Plan will pay 100% of your allowable medical and prescription drug costs.

In-Network Out-of-Pocket Maximum:

- \$6,000 Single (Employee only)
- \$12,000 Family (Employee+Spouse, Employee+Child, Family)

How Prescription Drugs Are Classified

A **generic drug** is a medication chemically equivalent to a brand name drug on which the patent has expired. Generic versions of brand name drugs contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs. See the section "Generics Preferred" for details about how the Plan pays benefits for generic drugs.

A **preferred brand-name drug** is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. A preferred brand drug is a drug that is included on the Plan's drug formulary list as a prescription drug product preferred by the Prescription Drug Program for dispensing. Preferred brand name drugs do not have a generic equivalent. These medicines have been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and have been selected by Express Scripts to be included in the formulary based on their proven clinical and cost effectiveness.

Non-preferred brand-name drugs are not included on the Plan's drug formulary list, and generally they are not covered by the Prescription Drug Program. These drugs usually have an alternative therapeutically-equivalent drug available. In the rare event that your medical condition requires a non-preferred drug, and if you have tried and failed with two similar drugs on the formulary list, your doctor may contact Express Scripts to ask to have a non-preferred drug authorized for you. If your request is approved, benefits for the non-preferred drug will be the same as they would be for the preferred brand. The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Drugs Requiring Prior Authorization

Some drugs require prior authorization. This means that Express Scripts will need to make sure these prescriptions meet the Plan's conditions for coverage. (You can contact Express Scripts for a current list of drugs that require prior authorization.) If a drug you take requires prior authorization, your physician will need to contact Express Scripts for a clinical review. If your prescription is authorized, you will pay your copay. If the prescription is not approved for coverage, and you and your physician decide that you should still take the prescribed drug that was not authorized, you will pay the full cost of the medication.

To determine if your medication requires prior authorization, **your physician** (not you) should call the Express Scripts' prior authorization line at 1-800-753-2851. The best way to avoid inconvenience is to have your physician call the prior authorization line before you go to the pharmacy or send for your prescription by mail. The prior authorization line is not for patient use. You cannot obtain prior authorization by calling this line yourself.

Dispensing Limits and Other Limits

To promote safety and appropriate and cost-effective use of prescription drugs, the Prescription Drug Program includes a "drug quantity management" feature. For certain prescription drugs, it places a limit on the quantity that can be dispensed at one time. Quantity dispensing limits are based on:

- The manufacturer's recommended dosage and duration of therapy;
- Common usage for episodic or intermittent treatment;
- FDA-approved recommendations and/or clinical studies; and
- Guidelines of the Plan.

In addition to the above limits, the Prescription Drug Program limits the number of days for which a prescription can be filled. For each prescription filled for a non-specialty drug, you can obtain a supply of up to 90 days. For each prescription filled for a specialty drug, you can obtain a supply of up to 30 days.

The Prescription Drug Program provides benefits for fertility drugs, **up to a lifetime maximum benefit of \$10,000**. Benefits are not otherwise available for the treatment of Infertility.

Step Therapy Program

"Step therapy" manages appropriate use of first-line, clinically effective, lower-cost drugs before using a more expensive second-line drug. Step therapy requires patients to receive a trial of one or more first-line drugs before prescriptions are covered for second-line drugs when medically appropriate.

To promote the use of cost-effective first-line therapy, the Prescription Drug Program applies step therapy for certain drug categories, including but not limited to the following:

- Arthritis and pain medicines (COX-2s) such as Celebrex;
- Blood pressure or heart medicines (angiotensin receptor antagonists) such as Diovan and Benicar;
- Asthma, allergic rhinitis, and chronic bronchitis medicines such as Aerospa;
- High cholesterol medicines (HMGs) such as Crestor and Vytarin; and

A physician can override the step therapy program **when appropriate for medical reasons** by submitting a prior authorization request to Express Scripts by calling 1-800-753-2851.

Express Scripts Specialty Pharmacy

Accredo is Express Scripts' full-service specialty pharmacy. It serves a wide range of patients, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and post-transplant needs. **All specialty drugs must be filled through Accredo (other than medications administered through your treating physician), though you are allowed one initial fill of a specialty drug at a retail pharmacy.**

Accredo offers a complete range of services and specialty drugs, many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medicine.

To begin receiving your specialty drugs through Accredo, call them toll-free at 1-800-803-2523.

Accredo services include:

- Patient counseling — convenient access to pharmacists and nurses who are specialty medicine experts;
- Patient education — education material;
- Convenient delivery — coordinated delivery to your home, your doctor's office, or other approved location;
- Refill reminders; and
- Language assistance — interpreting services for non-English-speaking patients.

Prescription Drug Program Exclusions

The following are not covered under the Prescription Drug Program:

- Drugs and medicines that ordinarily can be obtained without a prescription (i.e. over-the-counter medications);
- Erectile dysfunction drugs;
- Anabolic steroids (Winstrol, Anadrol-50, Oxandrin, Deca-Durabolin);
- Appetite suppressants and other weight loss products;
- Durable medical equipment (except for nebulizer/supplies, breathing devices-peak meters and breathing supplies) ;
- Injectable serums, vaccines or allergens;
- Legend hair growth products (e.g., Propecia);
- Legend hair removal products (e.g., Vaniqa);
- Legend vitamins (except prenatal vitamins, b-12 injection, vitamins with fluoride);
- Prescriptions that exceed the 90-day limit;
- All PPI prescriptions
- Not more than 1 replacement prescription for vacation override or lost or stolen prescription; and
- Any drug or chemical not approved by the Food and Drug Administration in the dosage prescribed, for the reason prescribed, or in the form prescribed. This includes, but is not limited to, non-FDA approved compounded drugs.

Note that if you participate in the HealthCare Flexible Spending Account, the portion you pay for over-the-counter medications may be eligible for reimbursement through your health care FSA if you submit a written prescription from your doctor for the medication.

For certain other prescription drug exclusions, please consult the section of this Booklet entitled "Expenses Not Covered."

Filing a Prescription Drug Claim

You do not need to file a claim if you use a participating pharmacy. You only need to complete a special order envelope when you use home delivery. On a refill, it is even easier; you can just call or go online and provide your credit card number.

If you use a nonparticipating pharmacy, you need to pay the full cost for the prescription and file a claim for reimbursement.

Information When You Need It at www.express-scripts.com

Go online to www.express-scripts.com for 24-hour access to information regarding the Prescription Drug Program. Use this website to:

- Find out about your copayment amounts;
- Verify coverage for eligible dependents;
- View or print a list of drugs included in the Plan's formulary;
- Locate participating retail pharmacies near you;
- Review your 12-month prescription history;
- Order refills; and
- Check the status of your mail order prescription.

Register now to access www.express-scripts.com. Once you are registered, you will have the information you need

The Express Scripts Mobile App

The Express Scripts mobile application (app) helps members make better decisions for healthier outcomes – anytime, anywhere. The app has earned a consistent 4.5 star rating for all versions beginning in 2015.

The app is compatible with most iPhone®, iPad®, Android™, Windows Phone®, Amazon and BlackBerry® mobile devices. To download the Express Scripts mobile app, members should search for “**Express Scripts**” in their mobile device’s app store and download it for free.

Note: Features available on the mobile app are based on the member’s plan design and the Perdue’s profile set-up.

Members who are not already registered via express-scripts.com will need to create a username and password by registering on the app before they can have a fully personalized mobile experience. The same username and password can be used to access express-scripts.com.

Members who have **Apple’s touch ID authentication** on their iPhone or iPad devices can enable it to login to their Express Scripts account on the mobile app, if desired.

Members can navigate to the mobile website from their internet browser on their mobile device. The mobile website has the same features and functionality as the Express Scripts mobile app.

Perdue Farms Inc. – ADV10

BluePreferred Option

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance make the Group Contract's terms and provisions binding on CareFirst and the Group.

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part. Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Individuals enrolled in the Plan are also covered by the Prescription Drug Program described in Appendix A. Appendix A is not part of the Evidence of Coverage or the Group Contract and is not administered by CareFirst—it is administered by Express Scripts. It is being provided together with this Evidence of Coverage solely for the convenience of the participants. As described more fully in the Evidence of Coverage, both covered medical expenses and covered prescription drug expenses count toward the Plan's deductibles and out-of-pocket maximums.

Group Name: Perdue Farms Inc. ADV10 BluePreferred

Account
Number(s): 67088

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. **Preferred Health Care Providers:** For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.
2. **Non-Preferred Health Care Providers:**
 - a. **Non-Preferred health care practitioner:** For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or Carefirst's established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.
 - b. **Non-Preferred hospital or health care facility:** For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or Carefirst's established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.
 - c. **Non-Preferred Emergency Services Health Care Provider:** CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:
 - 1) The Allowed Benefit stated in paragraphs 2.a., or 2.b.
 - 2) The amount negotiated with Preferred Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Preferred Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

- 3) The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Preferred Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.
- 4) The amount that would be paid under Medicare (part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

Adverse Decision means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: January 1st through December 31st.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of Eligible Members.

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member whereby CareFirst and the Member share in the payment for Covered Services.

Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that has contracted with CareFirst.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hooyer/stair lifts, ramps, shower/bath bench, items available without a prescription).

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one Copay.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

Deductible means the dollar amount of Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him/herself.

Dependent means a Member other than the Subscriber (e.g., the eligible spouse, etc.), meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained the Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment; or
6. Satisfaction of any combination of the above factors.

Designated Wellness Services Provider means a third party service provider contracted by Group to provide specific wellness services to Members. For purposes of this Evidence of Coverage, the Group's Designated Wellness Services Provider is a Non-Preferred Provider. Services provided by the Group's Designated Wellness Services Provider are as defined by the Group. For description of such services please contact the Group directly.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage means this agreement, which includes the acceptance, riders and amendments, if any, between the Group and CareFirst (also referred to as the Group Contract).

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA means the U.S. Food and Drug Administration.

Group means the Subscriber's employer/Plan Sponsor or other organization to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the Group Contract includes any riders and/or amendments attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Habilitative mean health care services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

Infusion Therapy means treatment that places therapeutic agents into the vein, including intravenous feeding.

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

Limiting Age means the maximum age to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Director means a board certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. Not primarily for the convenience of a patient or Health Care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

Member means an individual who meets all applicable eligibility requirements, is enrolled either as a Subscriber or Dependent, and for whom payment has been received by CareFirst.

Non-Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that does not contract with CareFirst.

Non-Preferred Health Care Provider means any Health Care Provider that is not a Preferred Provider.

Occupational Therapy means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

Paid Claims means the amount paid by CareFirst for Covered Services. Inter-Plan Arrangements Fees and Compensation are also included in Paid Claims. Other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator may also be included in Paid Claims.

Physical Therapy means the short-term treatment described below that can be expected to result in an improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan of Treatment means the plan written and given to CareFirst by the attending Health Care Provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The contracted Preferred Provider has the obligation of referring Members within the network. Preferred Provider relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another.

A listing of Preferred Providers may be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any Health Care Provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means:

1. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription."
2. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
3. Prescription Drugs do not include:
 - a. Compounded bulk powders that contain ingredients that:
 - 1) Do not have FDA approval for the route of administration being compounded, or
 - 2) Have no clinical evidence demonstrating safety and efficacy, or
 - 3) Do not require a prescription to be dispensed.
 - b. Compounded drugs that are available as a similar commercially available Prescription Drug unless:
 - 1) There is no commercially available bio-equivalent Prescription Drug; or
 - 2) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Private Duty Nursing means Skilled Nursing Care that is not rendered in a hospital/Skilled Nursing Facility.

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Service Area means CareFirst's Service Area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members.

Skilled Nursing Care, depending on the place of service/benefit, means:

Home Health Care	Outpatient Private Duty Nursing	Inpatient hospital/facility /Skilled Nursing Facility
Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).		Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member’s safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility).		
Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider.	Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.	
Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.		
Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.		

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition, absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist means a physician who is certified or trained in a specified field of medicine.

Specialty Drug means Prescription Drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns – requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy means the treatment of communication impairment and swallowing disorders. Speech Therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

Substance Use Disorder means:

1. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or
2. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family except for Benefits for Members Entitled to Medicare (Medicare Complementary) in which case Type of Coverage means Individual coverage. Additional categories of coverage do not apply to Benefits for Members Entitled to Medicare. Each Medicare-eligible person, including a Medicare-eligible Dependent, will be enrolled in an Individual Type of Coverage category under the Group Contract.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

A. **Requirements for Coverage**

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

1. The individual elects coverage;
2. The individual is entitled to Medicare, if Medicare Complementary coverage applicable;
3. The Group accepts the individual's election and notifies CareFirst; and
4. Payments are made on behalf of the Member by the Group.

B. **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section B.1., and as stated in the Termination of Coverage section of the Evidence of Coverage.

When an Employee enrolls a Dependent in the Plan, the enrollment constitutes a representation by the Employee that the individual meets the definition of a Dependent and is eligible for the Plan, and that the Employee will provide evidence of eligibility on request. The enrollment also constitutes an acknowledgement by the Employee that the Plan is relying on the Employee's representation of eligibility in accepting the enrollment of the Dependent. If the Employee fails to provide evidence of eligibility when requested, that failure is evidence of fraud and material misrepresentation and the Plan may terminate coverage for the individual, which termination may be retroactive to the date as of which the individual first become ineligible.

1. **Open Enrollment Period**

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

- a. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
- b. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

2. **Newly Eligible Subscriber**

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period or a special enrollment period.

3. **Special Enrollment Periods**

Special enrollment is allowed for certain individuals in conjunction with: (1) a loss of other coverage, (2) the acquisition of certain Dependent beneficiaries or (3) losing eligibility for Medicaid or CHIP coverage, or gaining eligibility for premium assistance under Medicaid or CHIP. The Subscriber or individual seeking special enrollment must provide notice within the time period described in the Eligibility Schedule. Enrollment will be effective as stated in the Eligibility Schedule.

These special enrollment periods are not the same as Medicare special enrollment periods.

If only the Subscriber is eligible under this Evidence of Coverage and dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

If retirees are eligible for coverage under this Evidence of Coverage, references to an employee shall be construed to include a retiree, except for references made in the context of special enrollment for certain individuals who lose coverage, as special enrollment for certain individuals who lose coverage is not applicable to retirees.

a. Special enrollment for certain individuals who lose coverage:

- 1) CareFirst will permit current employees and dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
- 2) Individuals eligible for special enrollment.
 - a) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:
 - (1) The employee and the Dependents are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
 - (3) The employee satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - b) When Dependent loses coverage. A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:
 - (1) The Dependent and the employee are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

- (3) The Dependent satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - (4) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph B.3.a.2)b), or the employee satisfies the criteria of paragraph B.3.a.2)a) of this section.
- 3) Conditions for special enrollment.
 - a) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph B.3.a.3)a) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:
 - (1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
 - (2) In the case of coverage offered through a health maintenance organization, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) ;
 - (3) In the case of coverage offered through a health maintenance organization, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual; and
 - (4) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

- b) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.
 - c) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph B.3.a.3)a) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.
 - d) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)
- 4) Applying for special enrollment and effective date of coverage. The Group or CareFirst will allow an employee a period of at least thirty (30) days after an event described above to request enrollment (for the employee or the employee's Dependent).
- a) Coverage will begin no later than the first day of the first (1st) calendar month beginning after the date the Group or CareFirst receives the request for special enrollment.

- b. Special enrollment with respect to certain Dependent beneficiaries:
- 1) Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2), of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
 - 2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph B.3.a.2)a), b), c), d), e), or f) of this section.
 - a) Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption.
 - b) Spouse of a participant only. An individual is described in this paragraph if either:
 - (1) The individual becomes the spouse of a participant; or
 - (2) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.
 - c) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:
 - (1) The employee and the spouse become married; or
 - (2) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.
 - d) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.
 - e) Current employee and a new Dependent. A current employee and an individual who is a dependent of the employee, are described in this paragraph if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.
 - f) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

- c. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

CareFirst will permit an employee or Dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

- 1) Termination of Medicaid or CHIP coverage. The employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.
- 2) Eligibility for employment assistance under Medicaid or CHIP. The employee or Dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

MEDICAL CHILD SUPPORT ORDERS

A. Definitions

1. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
 - a. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
 - b. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
2. Qualified Medical Support Order (QMSO) means a MCSO issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended.

B Eligibility and Termination

1. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage the child will not be enrolled until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.

2. Enrollment for such a child will not be denied because the child:
 - a. Was born out of wedlock.
 - b. Is not claimed as a dependent on the Subscriber's federal tax return.
 - c. Does not reside with the Subscriber.
 - d. Is covered under any Medical Assistance or Medicaid program.

3. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
 - a. The MCSO/QMSO is no longer in effect;
 - b. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or
 - c. If coverage is provided under an employer sponsored health plan;
 - 1) The employer has eliminated family member's coverage for all employees; or
 - 2) The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable state or federal law, the child will continue in this post-employment coverage.

C. **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

1. Send the non-insuring custodial parent ID cards, claims forms, the applicable evidence of coverage or member contract and any information needed to obtain benefits;
2. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
3. Provide benefits directly to:
 - a. The non-insuring parent;
 - b. The Health Care Provider of the Covered Services; or
 - c. The appropriate child support enforcement agency of any state or the District of Columbia.

TERMINATION OF COVERAGE

A. **Disenrollment of Individual Members**

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons:

1. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.
2. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.
3. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.
4. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.
5. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.
6. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

B. **Death of a Subscriber**

If Dependent coverage is available, in the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

C. **Effect of Termination**

No benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

D. **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

A. Continuation of Eligibility upon Loss of Group Coverage

1. Federal Continuation of Coverage under COBRA

If the Group health benefit Plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit Plan may be possible. The employer offering this Group health benefit Plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the Plan Administrator.

2. Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

COORDINATION OF BENEFITS; SUBROGATION

A. Coordination of Benefits

1. Applicability

- a. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
- b. If this COB provision applies, the Order of Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
 - 1) Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; and
 - 2) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is explained in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

2. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Evidence of Coverage.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

- a. An individually underwritten and issued, guaranteed renewable, specified disease policy;
- b. An intensive care policy, which does not provide benefits on an expense incurred basis;
- c. Coverage regulated by a motor vehicle reparation law;
- d. The first one-hundred dollars (\$100) per day of a hospital indemnity contract;
- e. An elementary and/or secondary school insurance program sponsored by a school or school system; or
- f. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

- a. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- b. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- c. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

3. **Order of Benefit Determination Rules**

- a. **General**
When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - 1) The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
 - 2) Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

b. **Rules**

This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

- 1) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a) Secondary to the Plan covering the person as a dependent; and
 - b) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

- 2) Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:
 - a) For a dependent child whose parents are married or are living together:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - (2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.
 - b) For a dependent child whose parents are separated, divorced, or are not living together:
 - (1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in 3.b.2)a) above also shall apply if: i) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child.

- (2) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:
 - (a) The Plan of the parent with custody of the child;
 - (b) The Plan of the spouse of the parent with the custody of the child;
 - (c) The Plan of the parent not having custody of the child; and then
 - (d) The Plan of the spouse of the parent who does not have custody of the child.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in a) and b) of this paragraph as if those individuals were parents of the child.
- 3) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 4) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:
 - a) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);
 - b) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 5) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

4. **Effect on the Benefits of this CareFirst Plan**

a. **When this Section Applies**

This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

b. **Reduction in this CareFirst Plan's Benefits**

When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

5. **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.

6. **Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

7. **Right of Recovery**

If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

B. Employer or Governmental Benefits

Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
2. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

C. Subrogation

1. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:
 - a. Caused by an act or omission of a third party; or
 - b. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or
 - c. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose. CareFirst will not subrogate a recovery made under Personal Injury Protection policy benefits.
2. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Evidence of Coverage, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid in benefits up to the amount received from or on behalf of the third party. CareFirst will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.
3. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.
4. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

For purposes of this provision, "made whole" means that the Member fully recovers all of their damages.

5. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Evidence of Coverage. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.
6. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in the “Choosing a Provider” subsection below. Other factors that may affect payment are found in Referrals, COB, Subrogation, the Inter-Plan Arrangements Disclosure, Inter-Plan Programs Ancillary Services, Exclusions, and Utilization Management Requirements.

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

- a. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider contracts with CareFirst or not relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.
- b. CareFirst makes payment for Covered Services but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Preferred Health Care Providers

- a. If a Member chooses a Preferred Health Care Provider, the cost to the Member is lower than if the Member chooses a Non-Preferred Health Care Provider. Throughout the Schedule of Benefits, payments are listed as either “in-network” (for a Preferred Health Care Provider) or “out-of-network” (for a Non-Preferred Health Care Provider).

If a Preferred Health Care Provider refers a Member to a Non-Preferred Health Care Provider, CareFirst will pay the in-network benefit, but the Member will still be responsible for the difference between CareFirst’s payment and the Non-Preferred Health Care Provider’s charge.

- b. Claims will be submitted directly to CareFirst by the Preferred Health Care Provider.
- c. CareFirst will pay benefits directly to the Preferred Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.
- d. The Member is responsible for any applicable Deductible and Coinsurance or Copayment, as stated in the Schedule of Benefits.

3. **Non-Preferred Health Care Providers**
 Except as otherwise authorized by CareFirst, if a Member chooses a Non-Preferred Health Care Provider, Covered Services may be eligible for reduced benefits. When Covered Services are provided by a Non-Preferred Health Care Provider, out-of-network benefits apply.
 - a. Claims may be submitted directly to CareFirst or its designee by the Non-Preferred Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
 - b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Preferred Health Care Provider, at the discretion of CareFirst.
 - c. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the appropriate department of an appropriate State (as designated in the order or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.
 - d. Non-Preferred Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Preferred Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Member is responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.
4. **Ambulance Services Providers**
 - a. For purposes of calculating the Member payment for Ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide	
If a Member receives Covered Services from:	Member liability:
Preferred Ambulance Services Provider	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Ambulance Services Provider	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Ambulance Services Provider's actual charge.

- b. If a Member receives services from a Preferred Provider, the cost to the Member is lower than if the Member receives services from a Non-Preferred Provider.
- C. **Notice of Claim**
 A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

D. **Claim Forms**

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

E. **Proofs of Loss**

In order to receive benefits for services rendered by a Health Care Provider who does **not** contract with CareFirst, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

1. Claims for medical benefits must be submitted within fifteen (15) months following the dates services were rendered.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the member, not later than one year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

F. **Time of Payment of Claims**

Benefits payable under this Evidence of Coverage will be paid not more than thirty (30) days after receipt of written proof of loss.

G. **Claim Payments Made in Error**

If CareFirst makes a claim payment to or on behalf of a Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

H. **Assignment of Benefits**

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Preferred Health Care Provider rendering Covered Services. A Member may not assign his or her right to bring a lawsuit under ERISA against Perdue, the Plan, the Plan Administrator, or CareFirst

I. **Evidence of Coverage**

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable. Only one statement will be issued for each family unit.

J. **Notices**

Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail or by first class mail to the most recent address for the Member in CareFirst's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

K. **Privacy Statement**

CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

L. **Prescription Drug Rebate Sharing**

CareFirst may be eligible for rebates from Prescription drug manufacturers upon negotiating directly with manufacturers.

CareFirst and the Plan Sponsor, as such is defined in the Administrative Services Agreement, agree to the extent to which any such rebates are shared.

REFERRALS

Referral Requirements

- A. Written referrals are not required.
- B. Referral to a Specialist or Non-Physician Specialist
1. Non-Physician Specialist means a Health Care Provider who is not a physician who is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any state or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.
 2. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and
 - a. CareFirst does not contract with a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
 - b. CareFirst cannot provide reasonable access to a contracted specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
 3. For purposes of calculating any Member payment, CareFirst will treat the services provided by the Specialist or Non-Physician Specialist as if the services were provided by a Preferred Health Care Provider.
- C. Referrals Quick Reference

While written referrals are not required, Covered Services with a referral will be available as follows:

For Covered Services:			
If a Member sees a:	With referral:	Without referral:	Member liability:
Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.		No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.	Covered Services will be paid at the out-of-network level of benefits if out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted for Covered Services: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Health Provider's actual charge.

This Referrals Quick Reference guide is subject to the terms stated in the Referral to a Specialist or Non-Physician Specialist section, above.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

Most Prescription Drugs classified as Specialty Drugs require prior authorization; prior authorization applies to Specialty Drugs covered under the medical portion of this Evidence of Coverage (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings). Specialty Drugs are defined in the Definitions section of this Evidence of Coverage. Preferred Health Care Providers will obtain prior authorization from CareFirst on behalf of the Member. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization/a Plan of Treatment. Failure to obtain prior authorization may result in denial of the claim.

A. Plan of Treatment

Certain outpatient services indicated throughout this Evidence of Coverage require CareFirst's approval of a Plan of Treatment before benefits for Covered Services are provided; a penalty may apply if such approval is not obtained.

1. A health care practitioner must complete and submit a Plan of Treatment.
2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.
3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.
4. Within the Service Area, a Preferred Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Preferred Health Care Provider or a Non-Preferred Health Care Provider.
5. Services for which CareFirst must approve a Plan of Treatment:
 - a. Controlled Clinical Trial Patient Cost coverage

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
 - b. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

c. Home Health Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late (forty-eight (48) hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

d. Hospice Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing hospice care, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

e. Private Duty Nursing

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

B. Hospital Pre-Certification and Review

A Preferred Health Care Provider, in and out of the Service Area, will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Preferred Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

- a. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.
- b. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.
- c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.
- d. Pre-operative days will not be approved for procedures unless Medically Necessary.
- e. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.
- f. CareFirst's payment will be based on the inpatient days approved by the reviewer.
- g. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.

- h. Hospital Pre-Certification and Review is not applicable to maternity admissions, and admissions for cornea and kidney transplants.
2. Non-Emergency (Elective) Admissions
- a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.
 - b. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.
 - c. CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - d. For Out-of-Network Covered Services:
 - 1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.
3. Emergency (Non-Elective) Admissions
- a. The Member, the Health Care Provider or another person acting on behalf of the Member must notify the reviewer within twenty-four (24) hours following the Member's admission, or as soon thereafter as reasonably possible.

The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify the reviewer of the emergency admission within twenty-four (24) hours if the Member's medical condition prevented the hospital from determining:

 - 1) The Member's insurance status; and
 - 2) The reviewer's emergency admission notification requirements.
 - b. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:
 - 1) During the first twenty-four (24) hours the Member is in an inpatient facility; or
 - 2) Until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a Member has been admitted and shall state the reasons for the admission.

- c. The reviewer will make all initial determinations on whether to approve a non-elective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

For non-elective admissions for which the reviewer receives notice but does not approve inpatient benefits, CareFirst will notify the hospital attending Health Care Provider that inpatient benefits will not be paid as of the date of notification.

- 1) A Member will have to pay:
 - a) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.
 - b) Non-Preferred Health Care Providers if a non-elective admission results in payment denial.
- 2) A Member will not have to pay Preferred Providers:
 - a) If the Member is admitted and the admission is not Medically Necessary;
 - b) If a non-elective admission results in payment denial.

- d. For Out-of-Network Covered Services:

- 1) CareFirst will not provide benefits for a non-elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
- 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the non-elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

- 4. Continued Stay Review
The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.
- 5. Discharge Planning
The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.

6. Program Monitoring
 - a. The Member's medical record will be reviewed by the reviewer.
 - b. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.
 - c. During and after discharge, the reviewer may review the medical records to:
 - 1) Verify that the services are covered under the Evidence of Coverage;
 - 2) Ensure that the Health Care Provider is substantially following the Plan of Treatment.
7. Notice and Appeals
 - a. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.
 - b. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.
 - 1) If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.
 - 2) For instructions on how to appeal an Adverse Decision, refer to the Claims Procedures of this Evidence of Coverage.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services

Overview

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan. The Inter-Plan Programs are described generally below.

When a Member receives care outside of CareFirst’s service area, it will be received from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. CareFirst explains below how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst’s service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst’s service area and care received outside the geographic area CareFirst serves is stated in the Definitions.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when a Member receives Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When a Member receives Covered Services outside CareFirst’s service area and the claim is processed through the BlueCard Program, the amount a Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount a Member pays for Covered Services under this arrangement will be calculated based on the negotiated price/lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to a Member, the Member will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, a Member will incur no liability, other than any related Member cost sharing.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside CareFirst's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount a Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, a Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

E. **Blue Cross Blue Shield Global Core Program**

If a Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), the Member may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit Member claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **Members must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Members pay for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submission, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs);
2. Medical Devices and Supplies; and
3. Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care).

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider or a Health Care Provider who contracts with the local Blue Cross and/or Blue Shield Licensee in that geographic area as stated in the Inter-Plan Arrangements Disclosure.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: <ul style="list-style-type: none">• Shipped to; or• Purchased at a retail store.	
Specialty Prescription Drugs	Ordering/prescribing physician is located.	

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE (Medicare Complementary)

The provisions in this section apply to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in this Evidence of Coverage. Benefits that are covered by Medicare are subject to the provisions in this section.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures; however, the Utilization Management Requirements of this Evidence of Coverage do not apply to persons for whom Medicare is the primary carrier.

Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Providers contracted with CareFirst, all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

This coverage is not Medicare supplemental coverage. This coverage provides benefits for some charges and services not covered by Medicare. It is not designed to fill the "gaps" of Medicare.

Covered Services under Medicare Complementary are the same as under the Description of Covered Services. Only the manner of payment is different:

- A. **Coverage Secondary to Medicare**
Except where prohibited by law, CareFirst benefits are secondary to Medicare.
- B. **Medicare as Primary**
 - 1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare:
 - a. For any Health Care Provider who accepts Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge.
 - b. For any Health Care Provider who does not accept Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the limitation set by Medicare.
 - 2. **For a Member who Elects Medicare Part B:** CareFirst will coordinate as described above and pay benefits based on Medicare's payment. For example, after meeting the Part B deductible, Medicare pays 80% of the Medicare approved amount for most doctor services; the basis for CareFirst's payment is the remaining 20% of the Medicare approved amount (the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge/limitation set by Medicare).

- a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming:	
Part B deductible has been met; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%; and Medicare approved charge does not exceed limitation set by Medicare, if applicable	
Medicare approved amount	\$ 1,000.00
Multiplied by 80% equals Medicare payment	\$ 800.00
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

3. **For a Member who Does not Elect Part B:** CareFirst will reduce its payment to “carve-out” or reject the 80% coinsurance Medicare would have paid if the Member had elected Part B.
- a. If the amount Medicare would have paid is available, CareFirst will coordinate as described above, “carving-out” or rejecting the amount Medicare would have paid. CareFirst will base its reduced Coinsurance payment on the amount Medicare would have paid if the Member had elected Part B.
- b. If the amount Medicare would have paid is not available, CareFirst will base its Coinsurance payment on 20% of the Allowed Benefit. The 80% reduction to the Allowed Benefit represents the amount that Medicare theoretically would have paid if the Member had elected Part B.
- c. Numerical Examples for a Member who Does not Elect Part B:
- 1) In the first numeric example below, CareFirst's Allowed Benefit is assumed to be the same as the Medicare approved amount in the above example for a Member who elects Medicare Part B. In this example, CareFirst's payment does not differ; however, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available;	
CareFirst Deductible, if applicable, has been met;	
CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 1,000.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

- 2) In the second numeric example below, CareFirst's Allowed Benefit is assumed to differ from the Medicare approved amount in the above example for a Member who elects Medicare Part B. Again, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available;	
CareFirst Deductible, if applicable, has been met;	
CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 500.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 100.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 100.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 80.00

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists other features that affect Member coverage, including, if applicable, the Deductible, Out-of-Pocket Maximum, and specific benefit limitations. It is also important to review the section entitled "Exclusions."

PREVENTIVE AND WELLNESS SERVICES

A. Covered Services:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
 - a. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.
 - b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.
 - c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
2. If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.
3. CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

AMBULANCE SERVICES

A. Covered Services

1. Medically Necessary air transportation, surface, and ground ambulance services, as determined by CareFirst.
 - a. Foreign Transportation: If the Member requires professional medical care for an injury or illness while traveling outside the United States, CareFirst or its authorized agent will cover the reasonable and necessary costs to transport the Member to a location where more appropriate medical care is available.

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Is approved by:
 - a. The National Institutes of Health (NIH) or a Cooperative Group.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - 1) To be comparable to the system of peer review of studies and investigations used by the NIH, and
 - 2) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - h. The FDA in the form of an investigational new drug application.
 - i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Evidence of Coverage for non-Investigational treatments.

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:
 - a. Treatment provided for a life-threatening condition; or,
 - b. Prevention, early detection, and treatment studies on cancer.
2. Coverage will be provided only if:
 - a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer; or,
 - b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;
 - c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,
 - e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.
3. Coverage is provided for the Patient Cost, including Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

DIABETES EQUIPMENT

Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

DIABETES SUPPLIES

Coverage will be provided for all Medically Necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

DIABETES SELF-MANAGEMENT TRAINING

1. Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
2. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

1. With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the Member.
2. Medically Necessary air transportation, surface, and ground ambulance services, as determined by CareFirst.
3. Urgent Care services.

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:
 - a. If the Member is:
 - 1) Seven years of age or younger, or developmentally disabled;
 - 2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and
 - 3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - b. Or, if the Member is:
 - 1) Seventeen years of age or younger;
 - 2) An extremely uncooperative, fearful, or uncommunicative individual;
 - 3) An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - 4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - c. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - d. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - 1) A fully accredited specialist in pediatric dentistry;
 - 2) A fully accredited specialist in oral and maxillofacial surgery; and
 - 3) A dentist who has been granted hospital privileges.
 - e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

HOME HEALTH CARE

A. Definitions

Home Health Care means the continued care and treatment of a Member by a Health Care Provider in the home if:

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and
2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

Home Health Care Visits means:

1. Each visit by a member of a Home Health Care team is considered one Home Health Care Visit; and
2. Up to four (4) hours of Home Health Care service is considered one Home Health Care visit.

B. Covered Services

1. Home Health Care, as defined above.
2. Home Visits Following Childbirth, including any services required by the attending Health Care Provider:
 - a. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or ninety-six (96) hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;
 - b. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):
 - 1) One home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge;
 - 2) An additional home visit following childbirth if prescribed by the attending Health Care Provider.
 - c. An attending Health Care Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Health Care Provider, attending the Member or newborn Dependent child(ren).
 - d. Home visits following childbirth must be rendered, as follows:
 - 1) In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
 - 2) By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

3. Home Visits Following the Surgical Removal of a Testicle
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - 1) One home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and
 - 2) An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

C. Limitations

1. The Member must be confined to “home” due to a medical condition. “Home” cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.
2. The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. “Skilled Nursing Care,” for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.
4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).
5. See additional limitations in the Schedule of Benefits.

HOSPICE CARE

A. Definitions

Caregiver means a person who is not a Health Care Provider who lives with or is the primary caregiver of the Member in the home. The Caregiver can be a relative by blood, marriage or adoption or a friend of the Member, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

1. Inpatient hospice facility services;
2. Part-time nursing care by or supervised by a registered graduate nurse;
3. Counseling, including dietary counseling, for the Member;
4. Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the Member;
5. Medical care by the attending physician;
6. Other Medically Necessary health care services at CareFirst's discretion.

Additionally, hospice care benefits are available for a Member's family (family is the spouse, parents, siblings, grandparents, child(ren), and/or Caregiver) for periodic family counseling before the Member's death, and bereavement counseling.

A Member, or representative of the Member, can petition CareFirst to review the Member's case and authorize an extension of coverage. CareFirst reserves the right to extend the hospice care eligibility period for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care, if it determines that the patient's prognosis and continued need for services are consistent with a program of hospice care. Additional "reserve" benefits (up to 45 days) apply if the Member exceeds: the Hospice Eligibility Period and/or the inpatient benefit limit.

INFERTILITY SERVICES

A. Definitions

Infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.

B. Covered Services

1. Benefits are available for the diagnosis of Infertility excluding artificial insemination/intrauterine insemination and in vitro fertilization.
2. Under the Prescription Drug Coverage (see APPENDIX A), benefits are available for fertility drugs, up to a lifetime maximum of \$10,000. Benefits are not otherwise available for the treatment of Infertility.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(ambulatory services; hospitalization; laboratory services)

A. Covered Services

1. Inpatient/outpatient medical care and consultations.

Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Health Care Provider and a Member. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

2. Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

3. Surgery, as follows:

a. Oral surgery, limited to:

- 1) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity not solely involving teeth.**
- 2) Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.**

Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

- 1) The injury did not arise while or as a result of biting or chewing; and**
- 2) Treatment is commenced within twelve (12) months of the injury or, if due to the nature of the injury treatment could not begin within twelve (12) months of the injury, treatment began within twelve (12) months of the earliest date that it would be medically appropriate to begin such treatment.**

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

- b. Medically Necessary surgical procedures, as determined by CareFirst.

If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

- 1) If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.
- 2) If the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

- c. Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are (i) Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention, or (ii) described in the following section, entitled "Mastectomy Related Services.

4. Inpatient/outpatient assistant if the surgery requires surgical assistance as determined by CareFirst.
5. Inpatient/outpatient anesthesia services by a Health Care Provider other than the operating surgeon.
6. Inpatient/outpatient chemotherapy.
7. Home Infusion Therapy.
8. Inpatient/outpatient radiation therapy.
9. Inpatient/outpatient renal dialysis.
10. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
11. Administration of injectable Prescription Drugs by a Health Care Provider.
12. Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), allergy testing.
13. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.

14. Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from oral surgery, and otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.
15. Elective sterilization.
16. Skilled Nursing Facility services.
17. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
18. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
2. Breast prostheses prescribed by a physician for a Member who has undergone a mastectomy and has not had breast reconstruction;
3. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member;
4. Inpatient hospital services for a minimum of forty-eight (48) hours following a mastectomy as a result of breast cancer. A Member may request a shorter length of stay if the Member decides, in consultation with the attending physician, that less time is needed for recovery.
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - 1) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
 - 2) An additional home visit if prescribed by the Member's attending physician.
 - b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician.

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services including:
 - a. Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:
 - 1) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support supplies and consultation; and
 - 2) Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B” or provided in the comprehensive guidelines for women’s preventive health supported by the Health Resources and Services Administration.
 - b. Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not identified in section A.1.a. above, and Ancillary Services provided during those visits. Benefits include Medically Necessary laboratory diagnostic tests and services not identified in section A.1.b. above, including, but not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
 - c. Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event;
 - d. Medically Necessary services for the normal newborn (an infant born at approximately forty (40) weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
 - e. Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;
 - f. Circumcision.
2. Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - a. A minimum of:
 - 1) forty-eight (48) hours following an uncomplicated vaginal delivery;
 - 2) ninety-six (96) hours following an uncomplicated cesarean section.
 - b. Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.
3. Coverage for victims of rape or incest.

4. Birthing classes: one course per pregnancy at a CareFirst approved facility.
5. Birthing centers.
6. Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
7. Benefits are available for comprehensive lactation support and counseling, by a Health Care Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

1. Is primarily and customarily used to serve a medical purpose;
2. Is not useful to a person in the absence of illness or injury;
3. Is ordered or prescribed by a physician or other qualified practitioner;
4. Is consistent with the diagnosis;
5. Is appropriate for use in the home;
6. Is reusable; and
7. Can withstand repeated use.

Medical Device means Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

1. Are primarily and customarily used to serve a medical purpose;
2. Are not useful to a person in the absence of illness or injury;
3. Are ordered or prescribed by a physician or other qualified practitioner;
4. Are consistent with the diagnosis;
5. Are appropriate for use in the home;
6. Cannot withstand repeated use; and
7. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
4. May be purely passive support or may make use of spring devices;
5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a Health Care Provider; and
5. Is removable and attached externally to the body.

B. Covered Services

1. **Durable Medical Equipment**

Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

2. **Hair Prosthesis**

Benefits are available for a hair prosthesis.

3. **Medical foods and nutritional substances**

Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

4. **Medical Supplies**

Benefits are available for Medical Supplies as such supplies are defined above.

5. **Orthotic Devices, Prosthetic Devices**

Benefits include:

- a. Supplies and accessories necessary for effective functioning of the Orthotic or Prosthetic Device;
- b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
- c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

6. **Repairs.** Benefits for the repair, maintenance or replacement of an Orthotic or Prosthetic Device require authorization or approval by CareFirst. Benefits are limited to:
- a. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
 - b. Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.
 - c. Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

**MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES,
INCLUDING BEHAVIORAL HEALTH TREATMENT**

Inpatient/outpatient mental health and Substance Use Disorder services, including behavioral health treatment.

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

Donor Services consist of services covered under the Evidence of Coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Recipient/Donor Services

When Member is a:	Benefits are available for:
Recipient	Benefits are available for both the Member recipient and the non-Member donor. Donor benefits are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services.

Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/ Investigational as determined by CareFirst.
2. Donor Services, limited to the extent stated above.
3. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.
4. Immunosuppressant maintenance drugs when prescribed for a covered transplant.
5. Organ transplant procurement benefits for the recipient, as follows:
 - a. Health services and supplies used by the surgical team to remove the donor organ.
 - b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.
 - c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
6. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;
2. Conform to all laws that apply to organ transplants; and
3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;
2. Diagnosis;
3. Type of surgery; and
4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

Benefits are available for Medically Necessary outpatient Private Duty Nursing, as determined by CareFirst. Benefits are not provided for Private Duty Nursing rendered in a hospital.

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits are available through Express Scripts for Pharmacy-dispensed Prescription Drugs. Please see Appendix A at the end of this Evidence of Coverage for a description of the Prescription Drug Program.	Benefits are available, and limited to, Prescription Drugs dispensed in the office of a Health Care Provider. Contraceptives: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.

PROFESSIONAL NUTRITIONAL COUNSELING/MEDICAL NUTRITION THERAPY

A. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

B. Covered Services

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

REHABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**

Benefits are available for inpatient Rehabilitative Services.

2. **Outpatient Rehabilitative Services**

Benefits are available for the following outpatient Rehabilitative Services:

a. Occupational Therapy;

b. Physical Therapy; and

c. Speech Therapy.

3. **Cardiac Rehabilitation**

Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide Cardiac Rehabilitation.

Benefits will not be provided for maintenance programs.

4. **Pulmonary Rehabilitation**

Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide pulmonary rehabilitation.

Benefits will not be provided for maintenance programs.

5. **Visual Therapy**

Benefits are available for outpatient visual therapy.

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Preferred Health Care Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
 2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
 3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including: flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
 - Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
 - Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).
 - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
 - All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the Member, unless otherwise a Covered Service.

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.
- Any procedure or treatment designed to alter an individual’s physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to health education classes and self-help programs, except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment, other than Medically Necessary and approved pulmonary rehabilitation programs and services provided by the Group’s Designated Wellness Services Provider.
- Medical or surgical treatment for obesity, unless otherwise specified in the Description of Covered Services.
- Medical or surgical treatment or regimen for reducing or controlling weight for morbid obesity.

These exclusions do not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.

- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomies and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.
- Non-medical Health Care Provider services, including, but not limited to:
 1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
 2. Administrative fees charged by a Health Care Provider to a Member to retain the Health Care Provider’s medical practice services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.
- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider’s charges and billed for by them.

- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).
- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.
- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.

- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.
- Immunizations solely for foreign travel.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in the Description of Covered Services.
- Hearing care except as otherwise stated.
- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.
- Work Hardening Programs. Work Hardening Programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

Ambulance Services

- Except Medically Necessary ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

Emergency Services

- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

General anesthesia and associated hospital or ambulatory surgical facility services for dental care

- Dental care for which general anesthesia is provided.

Home Health Care

- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.
- Respite care.

Infertility Services

- Medical or surgical treatment for Infertility, except as stated in the Description of Covered Services.

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.
- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.
- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).
- Acupuncture.
- Inpatient or outpatient orthodontic expenses for the treatment of cleft lip and/or cleft palate.
- Inpatient Private Duty Nursing.
- Procedures to reverse sterilization.
- Surgical removal of impacted teeth.
- Elective Abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother or expenses are incurred to treat medical complications due to the abortion or the pregnancy is the result of rape or incest.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Medical Supplies, except as stated in the Description of Covered Services, or any riders attached to this Evidence of Coverage.
- Orthotic Devices and Prosthetic Devices, except as stated in the Description of Covered Services.
- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

Mental health and Substance Use Disorder services, including behavioral health treatment

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses Incurred for the location of a suitable donor; e.g., search of a population or mass screening.

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services or Appendix A.

Rehabilitative Services

- Services delivered through early intervention and school services.
- Applied Behavioral Analysis services.

ELIGIBILITY SCHEDULE

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group.	
Spouse	Coverage for a Dependent spouse is available.	
Domestic Partner	Coverage Domestic Partners is not available.	
Dependent children	Coverage for Dependent children, excluding children of a Domestic Partner, is available.	Limiting Age Up to age 26
Unmarried incapacitated Dependent children	<p>A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:</p> <ol style="list-style-type: none"> 1. The Dependent child is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty (30) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated. 	Limiting Age Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber	<p>A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.</p> <p>A Subscriber who is not enrolled when the Group receives a QMSO is eligible for coverage effective on the date specified in the MCSO.</p>
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	<p>The employee must notify the Group, and the Group must notify CareFirst no later than thirty (30) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.</p>
Special enrollment for certain dependent beneficiaries	<p>The employee must notify the Group, and the Group must notify CareFirst during the thirty (30) day special enrollment period beginning, as follows:</p> <p>In the case of marriage: the date of marriage.</p> <p>In the case of a newly born child: the date of birth.</p> <p>In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent (or, if Dependent coverage is not generally available at the time of the adoption or the placement for adoption, a period of thirty (30) days after Dependent coverage is made generally available by the Group).</p>
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).</p> <p>A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.</p>

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the date eligibility ceases as determined by the Group.
Dependent child	A Dependent child will remain covered until the birthday when the Dependent child reaches the Limiting Age for a Dependent child .
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the date eligibility ceases as determined by the Group.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.
Subscriber changes the Type of Coverage to an Individual or other non-family contract (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Coverage will terminate on the date the Subscriber changes the Type of Coverage to an Individual or other non-family contract.
Death of a Subscriber	Coverage of any Dependents will terminate on the date determined by the Group.

SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced. See Utilization Management Requirements for these rules.

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

DEDUCTIBLE			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$600	\$1,500	\$1,500	\$3,000
Applicable to all in-network benefits, except as stated in the Description of Covered Services.		Applicable to all out-of-network benefits, except as stated in the Description of Covered Services.	
In-Network and Out-of-Network			
The in-network and out-of-network Deductible will be a combined amount.			
The Deductible is calculated based on the Allowed Benefit of Covered Services.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Deductible, then for the remainder of the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Deductible and the Family Deductible apply. If the Family Deductible has not been met for the Benefit Period, then a Member must meet the Individual Deductible before CareFirst will pay the benefit amounts specified in the Schedule of Benefits for that Member. If the Family Deductible has been met for the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits for all covered family Members.			
The following amounts are included/excluded from the Deductible:		Included	Excluded
Amounts in excess of the Allowed Benefit		No	Yes
Pharmacy-dispensed Prescription Drugs as provided in Appendix A		Yes	No

OUT-OF-POCKET MAXIMUM			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$5,000	\$10,000	\$10,000	\$17,000
In-Network and Out-of-Network			
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for the remainder of the Benefit Period.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum apply. If a covered family Member has met the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for that Member for the remainder of the Benefit Period. If a covered family Member has not met the Individual Out-of-Pocket Maximum, but the family as a whole has met the Family Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for all covered family Members for the remainder of the Benefit Period.			
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.			
The following amounts are included/excluded from the Out-of-Pocket Maximum:	Included	Excluded	
Amounts in excess of the Allowed Benefit	No	Yes	
Coinsurance (Member's share)	Yes	No	
Deductible	Yes	No	
Pharmacy-dispensed Prescription Drugs as provided in Appendix A	Yes	No	

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are not Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Adult preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Chlamydia screening	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Colorectal cancer screening		
Hepatitis C screening		
Human papillomavirus screening		
Mammography/breast cancer screening		
Osteoporosis prevention		
Prostate cancer screening		

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services	Limitations Ambulance services are limited, as follows: <ul style="list-style-type: none"> Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance. 	
Ambulance Services	90% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Limitations Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes equipment	90% of Allowed Benefit	70% of Allowed Benefit
Diabetes supplies	90% of Allowed Benefit	70% of Allowed Benefit
Diabetes self-management training	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services		
Emergency Services in a hospital emergency room/department		
Hospital emergency room/department and ancillary services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	90% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Outpatient professional practitioner(s) in hospital emergency room/department	90% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Member admitted as inpatient	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Hospital emergency room/department services for any condition that is not an Emergency Medical Condition	Please see “Medical care and consultations (illness visits)” table below.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office	90% of Allowed Benefit	70% of Allowed Benefit
Urgent Care center	90% of Allowed Benefit	50% of Allowed Benefit
Dental services related to accidental injury or trauma	Limitations Treatment must be provided within twelve (12) months from the date of the injury.	
	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
General anesthesia and associated hospital or ambulatory surgical facility services for dental care	Limitations An approved Plan of Treatment may be required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	Limitations An approved Plan of Treatment is required for Home Health Care. Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS) provided under the Total Care and Cost Improvement Program. Hospital/home health agency: Twenty (20) Home Health Care visits per Benefit Period.	
	Hospital/home health agency	90% of Allowed Benefit
	Home visits following childbirth	70% of Allowed Benefit
	Home visits following mastectomy	90% of Allowed Benefit
	Home visits following the surgical removal of a testicle	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care	Limitations An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and or family. Benefits for Hospice care services are limited to a maximum two-hundred and forty (240) days per Benefit Period. Benefits for bereavement counseling are limited to three (3) visits within one year of the family member's death.	
Facility/agency	90% of Allowed Benefit	90% of Allowed Benefit
Bereavement counseling	90% of Allowed Benefit	90% of Allowed Benefit
Family counseling	90% of Allowed Benefit	90% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient hospital or health care facility	Limitations Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
Facility	90% of Allowed Benefit	50% of Allowed Benefit
Inpatient practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Skilled Nursing Facility	Limitations Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 60 days per Benefit Period combined with Inpatient rehabilitation. Admission must be within fourteen (14) days of a hospital confinement of at least three (3) days.	
	No Deductible required 90% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	90% of Allowed Benefit	50% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Cleft lip or cleft palate, or both		
Oral surgery		
Facility	Benefits are available to the same extent as benefits provided for other surgical services.	
Outpatient professional practitioner	Benefits are available to the same extent as benefits provided for other surgical services.	
Office	Benefits are available to the same extent as benefits provided for other surgical services.	
Otological, audiological and speech/language treatment		
Hospital	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Outpatient professional practitioner	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Office	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	No prior authorization required for maternity admissions.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other outpatient care and medical supplies.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mastectomy-Related Services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	90% of Allowed Benefit	70% of Allowed Benefit
Hair prosthesis (Cancer diagnosis only)	Limitations Benefits for hair prosthesis are limited to \$500 per Benefit Period.	
	90% of Allowed Benefit	70% of Allowed Benefit
Medical foods and nutritional substances	90% of Allowed Benefit	70% of Allowed Benefit
Medical Supplies	90% of Allowed Benefit	70% of Allowed Benefit
Orthotic Devices, Prosthetic Devices	90% of Allowed Benefit	70% of Allowed Benefit
Treatment of temporomandibular joint dysfunction	Limitations Benefits for the treatment of temporomandibular joint dysfunction are limited to \$600 lifetime maximum.	
	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mental health and Substance Use Disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient Health Care Provider Services	Limitations Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services	Benefits for outpatient care are available, including: <ul style="list-style-type: none"> • Partial hospitalization; • methadone maintenance treatment; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy. 	
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests and X-Rays		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	90% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Other diagnostic services		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	90% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	Limitations Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services.	
Organ and tissue transplants and Related Services performed and/or provided at a Blue Distinction Center (BDC)	Organ/tissue transplant and services provided by a BDC for the first ninety (90) days from the date of transplant: No Deductible required 100% of Allowed Benefit Services provided by a BDC ninety (90) days <u>after</u> date of transplant: Benefit are available to the same extent as benefits provided for other illnesses.	No benefit
Organ and tissue transplants and transplant-related services provided by other providers (Non-Blue Distinction Centers)		
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel and lodging		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Services provided in an hospital emergency room for non-Emergency Medical Conditions and illness visits		
Hospital emergency room/department facility services	50% of Allowed Benefit after \$100 Copay* *Copay waived if Member is admitted.	50% of Allowed Benefit after \$100 Copay* *Copay waived if Member is admitted.
Outpatient professional practitioner services provided in an hospital emergency room/department	50% of Allowed Benefit	50% of Allowed Benefit
Services provided in other places of service for non-Emergency Medical Conditions and illness visits		
Outpatient hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office/home	90% of Allowed Benefit	70% of Allowed Benefit
Medical care and consultations at Perdue HealthWorks/Perdue Wellness Center		
Non-routine/non-preventive services	No Deductible required 100% of Allowed Benefit after \$15 Copay* *Copay applies to exam only.	Not applicable
Non-routine/non-preventive laboratory tests	No Deductible required 100% of Allowed Benefit after \$5 Copay	Not applicable
Preventive and wellness services and screenings	No Deductible required 100% of Allowed Benefit	Not applicable
Urgent Care center	Benefits are available to the same extent as benefits provided for Emergency Services provided in an Urgent Care facility.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Ambulatory surgical facility services	90% of Allowed Benefit	70% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	Paid same as in-network
Surgical assistant	90% of Allowed Benefit	Paid same as in-network
Female elective sterilization	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other out-of-network related services.
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Administration of injectable Prescription Drugs	90% of Allowed Benefit	70% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	90% of Allowed Benefit	70% of Allowed Benefit
Allergenic extracts (sera)	90% of Allowed Benefit	70% of Allowed Benefit
Allergy testing		
Outpatient Facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Chemotherapy		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Home Infusion Therapy	90% of Allowed Benefit	70% of Allowed Benefit
Inhalation therapy		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Radiation therapy		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Renal dialysis		
Hospital	90% of Allowed Benefit	Paid same as in-network
Outpatient professional practitioner	90% of Allowed Benefit	Paid same as in-network
Office	90% of Allowed Benefit	Paid same as in-network
Spinal manipulation	Limitations Spinal manipulation is limited to 25 days per Benefit Period.	
Office	90% of Allowed Benefit	70% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
Office	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	Limitations An approved Plan of Treatment is required. Outpatient private duty nursing is limited to 20 days per Benefit Period. No inpatient Private Duty Nursing benefits are available.	
	90% of Allowed Benefit	Paid same as in-network

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drugs	Limitations Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: <ul style="list-style-type: none"> injectable Prescription Drug contraceptives and contraceptive devices 	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy		
Office/home	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative Services		
Inpatient Rehabilitative Services	Limitations Hospital Pre-Certification and Review is required. Inpatient facility rehabilitation is limited to sixty (60) days per Benefit Period, combined with Skilled Nursing Facility.	
	No Deductible required 90% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Outpatient Rehabilitative Services		
Occupational Therapy	Limitations Benefits for Occupational Therapy are limited to 25 days per Benefit Period.	
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Physical Therapy	Limitations Benefits for Physical Therapy are limited to 25 days per Benefit Period.	
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Speech Therapy	Limitations Benefits for Speech Therapy are limited to 25 days per Benefit Period.	
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit
Cardiac Rehabilitation		
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Pulmonary Rehabilitation		
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Wellness services provided by the Group's Designated Wellness Services Provider	No Deductible required 100% of Allowed Benefit*	

* The Allowed Benefit is the Designated Wellness Services Provider's actual charge.

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

**TOTAL CARE AND COST IMPROVEMENT, PATIENT-CENTERED MEDICAL HOME,
ENHANCED MONITORING PROGRAM, EXPERT CONSULTATION PROGRAM, HEALTH
PROMOTION AND WELLNESS PROGRAM, AND DISEASE MANAGEMENT ADDENDUM**

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This Addendum is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. The effective date of coverage and termination date of coverage under this Addendum are the same as the effective date and termination date stated in the Group's Administrative Services Agreement for the benefits described herein.

The provisions of this Addendum do not apply to Members for whom Medicare is the primary carrier.

SECTION 1. DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage, for purposes of this Addendum, the underlined terms, below, when capitalized, have the following meaning:

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

Care Coordination Team, for purposes of the Patient-Centered Medical Home Program, means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, for purposes of the Patient-Centered Medical Home Program, means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses and includes case management through the Substance Use and Behavioral Health Program.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: Patient-Centered Medical Home Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Use and Behavioral Health Program, or other community-based programs outlined in this section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Enhanced Monitoring Program (EMP) means the CareFirst program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Expert Consultation Program (ECP) means the CareFirst Program for Members with a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

Health Promotion and Wellness Program means a coordinated program designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Health Care Provider, for purposes of the Patient-Centered Medical Home Program, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this section.

Qualifying Individual, for purposes of the Patient-Centered Medical Home Program, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Qualified Member means a Member who:

1. Is accepted by CareFirst into one or more of the TCCI Programs described in this section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.
2. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.
3. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.
4. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

Specialist, for purposes of the Patient-Centered Medical Home Program, means a licensed health care provider who is certified or trained in a specified field of medicine.

Substance Use and Behavioral Health Program, is a TCCI Program that includes a range of services that deal with the mental health of a Member (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program category are Substance Use services as well as psycho-social services.

Weight Loss Services means CareFirst approved services available to clinically obese Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion and Wellness Program.

Wellness Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Wellness Program.

SECTION 2. DESCRIPTION OF COVERED SERVICES

Benefits are available for:

A. TCCI Covered Services and Cost Sharing Waiver

1. Qualified Members are eligible for a waiver of certain cost sharing responsibility for benefits provided under this section when:
 - a. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or
 - b. At CareFirst's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in a CCM Program or a CCC Program.
2. Qualified Members participating in a CCM Program or a CCC Program as set forth in paragraph A.1.a., are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:
 - a. Assessment of Qualified Member/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;
 - b. Education of Qualified Member/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;
 - c. Assistance in navigating and coordinating health care services and understanding benefits;
 - d. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;
 - e. Assistance in arranging consultation(s) with Specialists;
 - f. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;
 - g. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.
 - h. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.
 - i. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

3. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under paragraph A.1.a., or, pursuant to CareFirst initiation under paragraph A.1.b., are eligible for benefits under following TCCI Program elements:
 - a. Comprehensive Medication Review (CMR). Benefits will be provided for a Pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.
 - b. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.
 - c. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.
 - d. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any Home Health Care visit limits stated in the Schedule of Benefits.
 - e. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.
 - f. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.
 - g. Substance Use and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and Substance Use Disorder services, including behavioral health treatment benefits.
4. Qualified Member Cost Sharing Responsibilities.
 - a. Any applicable cost-sharing responsibilities under this section (TCCI Covered Services and Cost Sharing Waiver) will be waived for (i) TCCI Program services provided by a Designated Provider, and (ii) in-network services provided to Qualified Members in an active plan of care.
 - b. Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits (ii) services provided in an inpatient institution or facility, or (iii) any services provided in a hospital.
 - c. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:
 - 1) If the Qualified Member has funded his/her HSA account during the calendar year, then the Qualified Member will be responsible for any associated costs for services under this section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

- 2) If the Qualified Member has not funded his/her HSA account during the calendar year, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in paragraph A.4.a.

5. Termination

- a. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this section will be terminated under the following circumstances:
 - 1) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner.
 - 2) When confirmed by the Qualified Member's treating physician or nurse practitioner if the TCCI Program(s) benefits are provided to Qualified Members not in an active plan of care.
 - 3) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.
 - 4) The Qualified Member's coverage under the Evidence of Coverage is terminated.
- b. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under paragraph A.5.a.3), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this section.
- c. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the effective date of the termination of the waiver.

B. PCMH Covered Services

Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.
2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.
3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;
4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

C. Enhanced Monitoring Program

Benefits for medical equipment and monitoring services will be provided to a Member, without an active plan of care, who qualifies under the EMP as determined by CareFirst.

D. Expert Consultation Program

Benefits for review of a Member's medical records by a team of specialists will be provided to a Member, without an active plan of care, who qualifies under the ECP as determined by CareFirst. The review of the Member's medical records will be done in accordance with the ECP.

E. Health Promotion and Wellness Covered Services

1. Health Assessments are available for all adult Members.
2. Benefits are available for Biometric Screening of Members, as defined above.
3. Lifestyle Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.
 - b. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).
4. Other Wellness Program benefits are available, which may include tobacco-cessation, well-being challenges, and financial well-being improvement programs.
5. Weight Loss Services are available to clinically obese Members, as follows:
 - a. A clinically obese Member is a Member whose Body Measurement Index (BMI) score is greater than thirty (30).
 - b. A dedicated, CareFirst approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.

- c. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

F. **Disease Management Covered Services**

- 1. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.
- 2. Disease Management Coaching Session services may be available as follows:
 - a. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.
 - b. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

SECTION 3. SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies, or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment, as stated below.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Total Care and Cost Improvement Program	Limitations Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for TCCI Program or Patient-Centered Medical Home Program.	
TCCI program services provided pursuant to a plan of care	No Deductible required 100% of Allowed Benefit	No benefit
TCCI Program elements		
TCCI program services provided without a plan of care: Enhanced Monitoring Program, Expert Consultation Program		
Patient-Centered Medical Home Program	Limitations Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst approved Health Care Provider who has elected to participate in the CareFirst Patient-Centered Medical Home Program.	
	No Deductible required 100% of Allowed Benefit	No benefit
Health Promotion and Wellness	Limitations Benefits for Weight Loss Services are only available to Members with a BMI score greater than thirty (30).	
Biometric Screening services	No Deductible required 100% of Allowed Benefit	No benefit
Wellness Coaching services		
Other Wellness Program services		
Weight Loss Programs		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Disease Management		
Disease Management services	No Deductible required 100% of Allowed Benefit	No benefit
Disease Management Coaching services	No Deductible required 100% of Allowed Benefit	No benefit

This Addendum is issued to be attached to the Evidence of Coverage.

CLAIMS PROCEDURES

Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group Health Plan has deemed itself subject to ERISA.

- A. DEFINITIONS**
- B. CLAIMS PROCEDURES**
- C. CLAIMS PROCEDURES COMPLIANCE**
- D. CLAIM FOR BENEFITS**
- E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)**
- F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**
- G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS**
- H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL**
- I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**
- J. NOTICE**
- K. EXTERNAL REVIEW PROCESS**

A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,
2. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Claimant's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

Group Health Plan means an employee welfare benefit Plan within the meaning of section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of section 733(a) of the Act.

Health Care Professional means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

Independent Review Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the claims administrator under this Group Contract.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Claimant's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeal of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Claimants.

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Rescissions are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.

C. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Claimant or authorized representative.

The above shall apply only in the case of a failure that:

- a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and
- b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

D. CLAIM FOR BENEFITS

A Claim for Benefits is a request for a Plan benefit or benefits made by a Claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

1. In general. Except as provided in paragraph E.2, if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.
2. The Claimant shall be notified of the determination in accordance with the following, as appropriate.
 - a. Expedited Notification of benefit determinations involving urgent care. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
 - 1) Receipt of the specified information, or
 - 2) The end of the period afforded the Claimant to provide the specified additional information.

- b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
- 1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
 - 2) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and Appeal shall be governed by paragraphs H.2.a, H.2.b, or H.2.c, herein as appropriate.
 - 3) Continued coverage will be provided pending the outcome of an Appeal.
- c. Other claims. In the case of a claim that is not an urgent care claim or a concurrent care decision the Claimant shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.
- 1) Pre-Service Claims. In the case of a Pre-Service Claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein.

- 2) **Post-Service Claims.** In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.
 - d. **Calculating time periods.** For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.c above due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
3. **Deemed exhaustion of internal claims and Appeals processes.** If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:
 - a. The specific reason or reasons for the adverse determination;
 - b. Reference to the specific Plan provisions on which the determination is based;
 - c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
 - d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the Act following an Adverse Benefit Determination on review;
 - e. In the case of an Adverse Benefit Determination:
 - 1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
 - 2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
 - f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.
2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in paragraph E.2.a herein, provided that a written or electronic Notification in accordance with paragraph F.1 of this section is furnished to the Claimant not later than three (3) days after the oral Notification.

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

1. To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within 180 days of the Adverse Benefit Determination.
2.
 - a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
 - b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;
 - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;
 - b. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
 - c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - d. Health Care Professionals engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and
 - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and
 - b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.
5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided below and in paragraph H.2, a Claimant shall be Notified in accordance with paragraph I. herein of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.
2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.
 - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.
 - b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

- c. Post-service claims. In the case of a Post-Service Claim, except as provided below, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
3. Calculating time periods. For purposes of paragraph H. herein, the period of time within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph I.1 herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs I.3, I.4, and I.5 herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;
4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and
5.
 - a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
 - b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and/or your State insurance regulatory agency.

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan's Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:
 - a. The Plan or the Plan's Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
 - b. The Plan or the Plan's Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan's Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.
 - c. The Plan or the Plan's Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.
 - d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.
 - e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.
2. Form and manner of Notice.
 - a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.
 - b. Requirements
 - 1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;
 - 2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and

- 3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.
- c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.
2. If a Claimant is in need of assistance, they may contact the appropriate state agency as follows:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Maryland Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571

<http://www.marylandattorneygeneral.gov/Pages/CPD/heau>

Additionally, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

3. Scope

- a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.
- b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:
 - 1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and
 - 2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

- a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:
 - 1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - 2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);

- 3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and
- 4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

- c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

- 1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- 2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- 3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.

- 4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.
- 5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
- (a) The Claimant's medical records;
 - (b) The attending health care professional's recommendation;
 - (c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;
 - (d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- 6) The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.

- 7) The assigned IRO's decision Notice will contain:
 - (a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;
 - (f) A statement that judicial review may be available to the Claimant; and
 - (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- 8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
- d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
5. Expedited External Review for self-insured Group Health Plans
 - a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:
 - 1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;

- 2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
- b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.
- c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.
- The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.
- d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.
6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

APPENDIX A

The Prescription Drug Program

Enrollment in the Plan automatically includes coverage under the Prescription Drug Program. This program is administered separately from your medical benefits under the Plan by Express Scripts.

How the Prescription Drug Program Works

The Prescription Drug Program offers you the following two ways to fill prescriptions:

- At a local participating pharmacy;
- By home delivery (mail order), phone or online.

After three fills at a retail pharmacy for a drug you use on an ongoing basis, often referred to as maintenance drugs, you will be asked to make a choice to continue filling at retail or move to the home delivery (mail order) service. Regardless of your choice of pharmacy, you should present the ID card you received at enrollment along with your prescription. This may allow the pharmacy to help you file a claim for benefits.

Your cost varies depending on the type of drug and how you choose to fill your prescriptions.

Retail – Participating Pharmacy

If you fill your prescription at a retail pharmacy that is an Express Scripts participating pharmacy, the pharmacist will charge you the appropriate copayment for your prescription. That is the only amount you pay. (See "Amount of Copayment" below for details.)

Your copayment at a participating pharmacy for up to a 30-day supply is:

- \$10 for generic non-specialty drugs;
- \$20 for generic specialty drugs;
- \$30 for preferred brand non-specialty drugs; and
- \$60 for preferred brand specialty drugs.

You will only be permitted one fill of a specialty drug at a retail pharmacy, and only for a 30-day supply. After that, you must use the Plan's home delivery (mail order) service.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

A separate copayment applies for each additional up-to-30-day supply you purchase. For example, if you purchase a 90-day supply from a participating retail pharmacy, your copayment will be \$30 for a generic non-specialty drug and \$90 for a preferred brand non-specialty drug.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

After three fills of a non-specialty prescription at a participating retail pharmacy, you will be asked to make a choice to continue filling at retail or move to the Plan's home delivery (mail order) service.

To find a participating retail pharmacy near you:

- Call Express Scripts toll-free at 1-800-211-8497;
- Access Express Scripts online at www.express-scripts.com; or
- Download the Express Scripts Mobile App.

Ask your local pharmacy if it is an Express Scripts participating pharmacy.

Retail – Nonparticipating Pharmacy

You must pay the full cost for your prescription when you use a nonparticipating pharmacy.

Express Scripts Home Delivery (Mail Order)

The Express Scripts mail service is a great way to fill prescriptions for medication you take on a long term or ongoing basis. You may receive up to a 90-day supply for one copayment. (See "Amount of Copayment or Coinsurance" below for details.)

Home delivery (mail order) may be your best option for prescription drugs that you take on a regular *basis for conditions such as asthma, high blood pressure, and high cholesterol*. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and sent to you in a plain, weather-resistant pouch for privacy and protection.

You may get up to a 90-day supply of your medications—which may mean fewer refills and fewer visits to your pharmacy, as well as lower costs. Once you begin using the home delivery, you can order refills online, by phone, through the mobile app or by mail.

You can choose between these easy options:

- Call Express Scripts at the toll-free number on the back of your member ID card and let Express Scripts do all the work. For most medications, Express Scripts will be able to contact your doctor for you and arrange for your first mail-order supply.
- Visit www.express-scripts.com/StartHD. After logging in, select “Transfer your retail prescriptions” to get started. The Express Scripts Pharmacy will contact your doctor for you to obtain a 90-day prescription.
- Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate). Then, ask your doctor to electronically send the prescription to the Express Scripts Pharmacy.

To transfer any remaining maintenance medication refills from a retail pharmacy to home delivery, log in or register at **Express-Scripts.com** and look for “Transfer to Home Delivery” on the home page. Select the medications you’d like to transfer, click “Add to Cart” and checkout. Express Scripts does the rest.

Orders are usually processed 48 hours from when Express Scripts gets them. Your medicine should be delivered in about 8 days (10-14 days if it's a new prescription). If Express Scripts needs to contact your doctor for information, delivery may take longer. You can check your order status by going online anytime. Your prescription drug will be mailed to your home at no charge for standard U.S. Postal Service delivery. You may request overnight delivery for an additional charge. You may also indicate if you want your medicine in a child-resistant or non-child-resistant bottle.

A pharmacist is available 24 hours a day to answer questions about your medicines.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

Your copayment for each prescription filled through home delivery is:

- \$20 for generic non-specialty drugs;
- \$20 for generic specialty drugs;
- \$60 for preferred brand non-specialty drugs; and
- \$60 for preferred brand specialty drugs.

Home delivery of a 90-day supply of insulin, syringes, and diabetic supplies, will be covered at the same rate as a retail 30-day supply.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Amount of Copayment

The amount of your copayment or coinsurance depends on where your prescription is filled, whether it is filled with a generic or brand drug, and whether it is for a specialty or non-specialty drug.

Type of Drug	In-Network Retail	Mail Order	Out-of-Network
Generic Non-Specialty	\$10 copay (30-day supply)	\$20 copay (90-day supply)	not covered
Generic Specialty	\$20 copay (30-day supply) (1 fill only)	\$20 copay (30-day supply)	not covered
Preferred Brand Non-Specialty	\$30 copay (30-day supply)	\$60 copay (90-day supply)	not covered
Preferred Brand Specialty	\$60 copay (30-day supply) (1 fill only)	\$60 copay (30-day supply)	not covered
Insulin, Syringes, and Diabetic Supplies	Retail copay applies (30-day supply)	Retail copay applies (90-day supply)	not covered

Your medical and prescription drug claims are combined when determining whether you have met the In-Network Out-of-Pocket Maximum. Once the In-Network Out-of-Pocket maximum amount is met, the Plan will pay 100% of your allowable medical and prescription drug costs.

In-Network Out-of-Pocket Maximum:

- \$5,000 Single (Employee only)
- \$10,000 Family (Employee+Spouse, Employee+Child, Family)

How Prescription Drugs Are Classified

A **generic drug** is a medication chemically equivalent to a brand name drug on which the patent has expired. Generic versions of brand name drugs contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs. See the section "Generics Preferred" for details about how the Plan pays benefits for generic drugs.

A **preferred brand-name drug** is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. A preferred brand drug is a drug that is included on the Plan's drug formulary list as a prescription drug product preferred by the Prescription Drug Program for dispensing. Preferred brand name drugs do not have a generic equivalent. These medicines have been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and have been selected by Express Scripts to be included in the formulary based on their proven clinical and cost effectiveness.

Non-preferred brand-name drugs are not included on the Plan's drug formulary list, and generally they are not covered by the Prescription Drug Program. These drugs usually have an alternative therapeutically-equivalent drug available. In the rare event that your medical condition requires a non-preferred drug, and if you have tried and failed with two similar drugs on the formulary list, your doctor may contact Express Scripts to ask to have a non-preferred drug authorized for you. If your request is approved, benefits for the non-preferred drug will be the same as they would be for the preferred brand. The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Drugs Requiring Prior Authorization

Some drugs require prior authorization. This means that Express Scripts will need to make sure these prescriptions meet the Plan's conditions for coverage. (You can contact Express Scripts for a current list of drugs that require prior authorization.) If a drug you take requires prior authorization, your physician will need to contact Express Scripts for a clinical review. If your prescription is authorized, you will pay your copay. If the prescription is not approved for coverage, and you and your physician decide that you should still take the prescribed drug that was not authorized, you will pay the full cost of the medication.

To determine if your medication requires prior authorization, **your physician** (not you) should call the Express Scripts' prior authorization line at 1-800-753-2851. The best way to avoid inconvenience is to have your physician call the prior authorization line before you go to the pharmacy or send for your prescription by mail. The prior authorization line is not for patient use. You cannot obtain prior authorization by calling this line yourself.

Dispensing Limits and Other Limits

To promote safety and appropriate and cost-effective use of prescription drugs, the Prescription Drug Program includes a "drug quantity management" feature. For certain prescription drugs, it places a limit on the quantity that can be dispensed at one time. Quantity dispensing limits are based on:

- The manufacturer's recommended dosage and duration of therapy;
- Common usage for episodic or intermittent treatment;
- FDA-approved recommendations and/or clinical studies; and
- Guidelines of the Plan.

In addition to the above limits, the Prescription Drug Program limits the number of days for which a prescription can be filled. For each prescription filled for a non-specialty drug, you can obtain a supply of up to 90 days. For each prescription filled for a specialty drug, you can obtain a supply of up to 30 days.

The Prescription Drug Program provides benefits for fertility drugs, **up to a lifetime maximum benefit of \$10,000**. Benefits are not otherwise available for the treatment of Infertility.

Step Therapy Program

"Step therapy" manages appropriate use of first-line, clinically effective, lower-cost drugs before using a more expensive second-line drug. Step therapy requires patients to receive a trial of one or more first-line drugs before prescriptions are covered for second-line drugs when medically appropriate.

To promote the use of cost-effective first-line therapy, the Prescription Drug Program applies step therapy for certain drug categories, including but not limited to the following:

- Arthritis and pain medicines (COX-2s) such as Celebrex;
- Blood pressure or heart medicines (angiotensin receptor antagonists) such as Diovan and Benicar;
- Asthma, allergic rhinitis, and chronic bronchitis medicines such as Aerospans; and
- High cholesterol medicines (HMGs) such as Crestor and Vytorin.

A physician can override the step therapy program **when appropriate for medical reasons** by submitting a prior authorization request to Express Scripts by calling 1-800-753-2851.

Express Scripts Specialty Pharmacy

Accredo is Express Scripts' full-service specialty pharmacy. It serves a wide range of patients, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and post-transplant needs. **All specialty drugs must be filled through Accredo (other than medications administered through your treating physician), though you are allowed one initial fill of a specialty drug at a retail pharmacy.**

Accredo offers a complete range of services and specialty drugs, many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medicine.

To begin receiving your specialty drugs through Accredo, call them toll-free at 1-800-803-2523. Accredo services include:

- Patient counseling — convenient access to pharmacists and nurses who are specialty medicine experts;
- Patient education — education material;
- Convenient delivery — coordinated delivery to your home, your doctor's office, or other approved location;
- Refill reminders; and
- Language assistance — interpreting services for non-English-speaking patients.

Prescription Drug Program Exclusions

The following are not covered under the Prescription Drug Program:

- Drugs and medicines that ordinarily can be obtained without a prescription (i.e. over-the-counter medications);
- Erectile dysfunction drugs;
- Anabolic steroids (Winstrol, Anadrol-50, Oxandrin, Deca-Durabolin);
- Appetite suppressants and other weight loss products;
- Durable medical equipment (except for nebulizer/supplies, breathing devices-peak meters and breathing supplies);
- Injectable serums, vaccines or allergens;
- Legend hair growth products (e.g., Propecia);
- Legend hair removal products (e.g., Vaniqa);
- Legend vitamins (except prenatal vitamins, b-12 injection, vitamins with fluoride);
- Prescriptions that exceed the 90-day limit;
- All PPI prescriptions
- Not more than 1 replacement prescription for vacation override or lost or stolen prescription; and
- Any drug or chemical not approved by the Food and Drug Administration in the dosage prescribed, for the reason prescribed, or in the form prescribed. This includes, but is not limited to, non-FDA approved compounded drugs.

Note that if you participate in the HealthCare Flexible Spending Account, the portion you pay for over-the-counter medications may be eligible for reimbursement through your health care FSA if you submit a written prescription from your doctor for the medication.

For certain other prescription drug exclusions, please consult the section of this Booklet entitled "Expenses Not Covered."

Filing a Prescription Drug Claim

You do not need to file a claim if you use a participating pharmacy. You only need to complete a special order envelope when you use home delivery. On a refill, it is even easier; you can just call or go online and provide your credit card number.

If you use a nonparticipating pharmacy, you need to pay the full cost for the prescription and file a claim for reimbursement.

Information When You Need It at www.express-scripts.com

Go online to www.express-scripts.com for 24-hour access to information regarding the Prescription Drug Program. Use this website to:

- Find out about your copayment amounts;
- Verify coverage for eligible dependents;
- View or print a list of drugs included in the Plan's formulary;
- Locate participating retail pharmacies near you;
- Review your 12-month prescription history;
- Order refills; and
- Check the status of your mail order prescription.

Register now to access www.express-scripts.com. Once you are registered, you will have the information you need.

The Express Scripts Mobile App

The Express Scripts mobile application (app) helps members make better decisions for healthier outcomes – anytime, anywhere. The app has earned a consistent 4.5 star rating for all versions beginning in 2015.

The app is compatible with most iPhone®, iPad®, Android™, Windows Phone®, Amazon and BlackBerry® mobile devices. To download the Express Scripts mobile app, members should search for “**Express Scripts**” in their mobile device’s app store and download it for free.

Note: Features available on the mobile app are based on the member’s plan design and the Perdue’s profile set-up.

Members who are not already registered via express-scripts.com will need to create a username and password by registering on the app before they can have a fully personalized mobile experience. The same username and password can be used to access express-scripts.com.

Members who have **Apple’s touch ID authentication** on their iPhone or iPad devices can enable it to login to their Express Scripts account on the mobile app, if desired.

Members can navigate to the mobile website from their internet browser on their mobile device. The mobile website has the same features and functionality as the Express Scripts mobile app.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$1,200 individual/ \$2,400 family Out-of-Network: \$2,400 individual/ \$4,800 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care Services and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-Network: \$6,000 individual/\$12,000 family Out-of-Network: \$12,000 individual/\$24,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, health care this plan doesn't cover, most out-of-network coinsurance you pay, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.carefirst.com or call 1-844-405-2160 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Specialist visit	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Retail health clinic	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	Deductible, then 30% of Allowed Benefit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Some services may have limitations or exclusions. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com	Generic non-specialty drugs	Retail: 20%, subject to \$8 minimum and \$16 maximum Mail Order: 20%, subject to \$16 minimum, \$32 maximum	Not covered	Drugs not listed on the formulary are not covered. ♦ Retail non-specialty drugs are limited to a 30-day supply. Mail Order non-specialty drugs are limited to a 90-day supply. All specialty drugs are limited to a 30-day supply and most must be obtained (after the first fill) through Express Scripts' home delivery service, Accredo. ♦ If a brand drug is requested when a generic drug is available, you pay the generic copay plus the difference in cost between the brand drug and the generic drug. ♦ Over-the-counter and erectile dysfunction drugs are not covered. ♦ Lifetime maximum of \$10,000 for fertility drugs. ♦ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
	Preferred brand non-specialty drugs	Retail: 20%, subject to \$30 minimum and \$60 Mail Order: 30%, subject to \$50 minimum, \$100 maximum	Not covered	
	Generic specialty drugs	Retail and Mail Order: 20%, subject to \$16 minimum, \$32 maximum	Not covered	
	Preferred brand Specialty drugs	Retail and Mail Order: 20%, subject to \$50 minimum, \$100 maximum	Not covered	
	Insulin, syringes, and diabetic supplies	Retail copay applies to both Retail and Mail Order prescriptions and supplies	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Limited to Emergency Services or unexpected, urgently required services. For other services, you pay: deductible, then \$100 copay, then 50% of Allowed Benefit (copay waived if admitted).
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Urgent care	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
If you are pregnant	Office visits	No Charge	Deductible, then 30% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Treatment plan must be approved before benefits will be paid. Benefits are limited to 20 visits per benefit period.
	Rehabilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Benefits are limited to 25 visits per benefit period for each type of therapy (Occupational, Speech, and Physical).
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% of Allowed Benefit	30% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50%. Benefits are limited to 60

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				days per benefit period. Admission must be within 14 days of a hospital confinement of at least 3 days. Outpatient Private Duty Nursing: Prior authorization is required. Without prior authorization, benefits will not be paid. Benefits are limited to 20 days per benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Benefits are limited to 240 days per benefit period.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult) Habilitation Services 	<ul style="list-style-type: none"> Hearing aids Infertility treatment Long-term care 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care Weight loss programs Non-surgical care for temporomandibular joint disorder (TMJ) (plan pays up to a lifetime max of \$600) 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> Chiropractic care (limited to 25 visits per benefit period) 	<ul style="list-style-type: none"> Coverage provided outside the US. See www.carefirst.com 	<ul style="list-style-type: none"> Non-emergency care when travelling outside the US Private-duty nursing (limited to 20 days per benefit period) 	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a
SBC ID: SBC20170816MANPerdueFarmsIncPPON0012018

Perdue 000820

grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$0
Coinsurance	\$1,822
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,032

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,400

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$0
Coinsurance	\$140
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,340

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$600 individual/ \$1,500 family Out-of-Network: \$1,500 individual/ \$3,000 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-Network: \$5,000 individual/\$10,000 family Out-of-Network: \$10,000 individual/\$17,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, health care this plan doesn't cover, most out-of-network coinsurance you pay, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.carefirst.com or call 1-844-405-2160 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Specialist visit	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Retail health clinic	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	Deductible, then 30% of Allowed Benefit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Some services may have limitations or exclusions. Please see your contract
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com	Generic non-Specialty drugs	Retail: \$10 copay Mail Order: \$20 copay	Not covered	Drugs not listed on the formulary are not covered. ♦ Retail non-specialty drugs are limited to a 30-day supply. Mail Order non-specialty drugs are limited to a 90-day supply. All specialty drugs are limited to a 30-day supply and most must be obtained (after the first fill) through Express Scripts' home delivery service, Accredo. ♦ If a brand drug is requested when a generic drug is available, you pay the generic copay plus the difference in cost between the brand drug and the generic drug. ♦ Over-the-counter and erectile dysfunction drugs are not covered. ♦ Lifetime maximum of \$10,000 for fertility drugs. ♦ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
	Preferred brand non-Specialty drugs	Retail: \$30 copay Mail Order: \$60 copay	Not covered	
	Generic Specialty drugs	\$20 copay	Not covered	
	Preferred brand Specialty drugs	\$60 copay	Not covered	
	Insulin, syringes, and diabetic supplies.	Retail copay applies to both Retail and Mail Order insulin, syringes, and diabetic supplies	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Limited to Emergency Services or unexpected, urgently required services. For other services, you pay: deductible, then \$100 copay, then 50% of Allowed Benefit (copay waived if admitted).
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	None
	Urgent care	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
If you are pregnant	Office visits	No Charge	Deductible, then 30% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only.
	Childbirth/delivery professional services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
If you need help recovering or have other special health needs	Home health care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Treatment plan must be approved before benefits will be paid. Benefits are limited to 20 visits per benefit period.
	Rehabilitation services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Benefits are limited to 25 visits per benefit period for each type of therapy (Occupational, Speech, and Physical).
	Habilitation services	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	10% of Allowed Benefit	30% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50%. Benefits are limited to 60 days per benefit period. Admission must be within 14 days of a hospital confinement of at least 3 days. Outpatient Private Duty Nursing: Without prior authorization, services are not covered. Benefits are limited to 20 days per benefit period.
	Durable medical equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	Benefits are limited to 240 days per benefit period.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Non-surgical care for temporomandibular joint disorder (TMJ) (plan pays up to a lifetime max of \$600)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (limited to 25 visits per benefit period)
- Coverage provided outside the US. See www.carefirst.com
- Private-duty nursing (limited to 20 days per benefit period)
- Non-emergency care when travelling outside the US

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$600
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$40
Coinsurance	\$967
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$1,617

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$600
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$700
Coinsurance	\$199
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,499

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$600
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$130
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$730

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,200 individual/\$2,400 family Out-of-Network: \$2,400 individual/\$4,800 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan , each family member may need to meet their own individual deductible , OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care visit, Specialist visit, Retail health clinic, Diagnostic test, Urgent care, Mental Health Outpatient services, Rehabilitation services and Skilled nursing care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Prescription Drug combined: In-Network: \$6,000 individual/\$12,000 family Out-of-Network: \$12,000 individual/\$24,000 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: \$30 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Specialist visit	Provider: \$50 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Retail health clinic	\$30 copay per visit	Deductible, then 40% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	Deductible, then 40% of Allowed Benefit	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital & PCP: \$30 copay per visit Specialist: \$50 copay per visit Hospital: Deductible, then 20% of Allowed Benefit X-Ray:	Lab Tests: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Non-Hospital & : PCP \$30 copay per visit Specialist: \$50 copay per visit Hospital: Deductible, then 20% of Allowed Benefit		
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: www.expressscripts.com	Generic non-Specialty drugs	Retail: 20%, subject to \$8 minimum, \$16 dollar maximum copay Mail Order: 20%, subject to \$16 dollar minimum, \$32 dollar maximum copay	Not covered	Drugs not listed on the formulary are not covered. ♦ Retail non-specialty drugs are limited to a 30-day supply. Mail Order non-specialty drugs are limited to a 90-day supply. All specialty drugs are limited to a 30-day supply and most must be obtained (after the first fill) through Express Scripts' home delivery service, Accredo. ♦ If a brand drug is requested when a generic drug is available, you pay the generic copay plus the difference in cost between the brand drug and the generic drug. ♦ Over-the-counter and erectile dysfunction drugs are not covered. ♦ Lifetime maximum of \$10,000 for fertility drugs. ♦ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
	Preferred brand non-specialty drugs	Retail: 20%, subject to a \$30 minimum, \$60 maximum copay Mail Order: 30%, subject to a \$50 minimum, \$100 maximum copay	Not covered	
	Generic specialty drugs	Retail & Mail Order: 20%, subject to \$16 minimum, \$32 maximum copay	Not covered	
	Preferred brand Specialty drugs	Retail & Mail Order: 30%, subject to \$50 minimum, \$100 maximum copay	Not covered	
	Insulin, syringes, and diabetic supplies	Retail copay applies to both Retail & Mail order prescriptions and supplies	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 20% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital:	Non-Hospital & Hospital:	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	
If you need immediate medical attention	Emergency room care	Deductible, then \$100 copay per visit, then 20% of Allowed Benefit	Paid as in Network	Limited to Emergency Services or unexpected, urgently required services. For other services, you pay Deductible, then \$100 copay, then 50% of Allowed Benefit. Copay waived if admitted.
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	None
	Urgent care	\$30 copay per visit	Deductible, then 40% of Allowed Benefit	Limited to unexpected, urgently required services.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits & Visit: \$30 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Office Visits & Hospital Facility: Deductible, then 40% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply.
	Inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%. Prior authorization is required.
If you are pregnant	Office visits	No Charge	Deductible, then 40% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Additional professional charges may apply.
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Treatment plan must be approved before benefits will be paid. Benefits are limited to 20 visits per benefit period.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	Office Visit: \$50 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 40% of Allowed Benefit	Benefits are limited to 25 visits per benefit period for each type of therapy (Occupational, Speech and Physical).
	Habilitation services	Office Visit: \$50 copay per visit Hospital Facility: Deductible, then 20% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 40% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits are limited to 25 visits per benefit period
	Skilled nursing care	20% of Allowed Benefit	40% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50%. Benefits are limited to 60 days per benefit period. Admission must be within 14 days of a hospital confinement of at least 3 days. Outpatient Private Duty Nursing: Prior authorization is required. Benefits are limited to 20 days per benefit period.
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	None
	Hospice services	Inpatient & Outpatient Care: Deductible, then 20% of Allowed Benefit	Inpatient & Outpatient Care: Deductible, then 20% of Allowed Benefit	Prior authorization is required. Benefits are limited to 240 days per benefit period.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs • Non-surgical care for temporomandibular joint disorder (TMJ) (plan pays up to a lifetime max of \$600) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (limited to 25 visits per benefit period)
- Coverage provided outside the US. See www.carefirst.com
- Non-emergency care when travelling outside the US
- Private-duty nursing (limited to 20 days per benefit period)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6518.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on Employee-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,200
■ Specialist	\$50
■ Hospital (facility)	20%
■ Other	\$30

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$100
Coinsurance	\$1,782
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$3,092

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,200
■ Specialist	\$50
■ Hospital (facility)	20%
■ Other	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$130
Coinsurance	\$1,120
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,450

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,200
■ Specialist	\$50
■ Hospital (facility)	20%
■ Other	\$50

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$300
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,540

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$600 individual/\$1,500 family Out-of-Network: \$1,500 individual/\$3,000 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan , each family member may need to meet their own individual deductible , OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible ?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care visit, Specialist visit, Retail health clinic, Diagnostic test , Urgent care, Mental Health Outpatient services, Rehabilitation services and Skilled nursing care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Medical and Prescription Drug combined: In-Network: \$5,000 individual/\$10,000 family; Out-of-Network: \$10,000 individual/\$17,000 family.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: \$30 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Specialist visit	Provider: \$50 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Retail health clinic	\$30 copay per visit	Deductible, then 30% of Allowed Benefit	None
	Preventive care/screening/immunization	No Charge	Deductible, then 30% of Allowed Benefit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital & PCP: \$30 copay per visit Specialist: \$50 copay per visit Hospital: Deductible, then 10% of Allowed Benefit	Lab Tests: Non-Hospital & Hospital: Deductible, then 40% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital & Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: www.expressscripts.com	Generic non-Specialty drugs	Retail: \$10 copay Mail Order: \$20 copay	Not covered	Drugs not listed on the formulary are not covered. ♦ Retail non-specialty drugs are limited to a 30-day supply. Mail Order non-specialty drugs are limited to a 90-day supply. All specialty drugs are limited to a 30-day supply and most must be obtained (after the first fill) through Express Scripts' home delivery service, Accredo. ♦ If a brand drug is requested when a generic drug is available, you pay the generic copay plus the difference in cost between the brand drug and the generic drug. ♦ Over-the-counter and erectile dysfunction drugs are not covered. ♦ Lifetime maximum of \$10,000 for fertility drugs. ♦ Prior authorization and step therapy are required for certain drug categories. Without prior authorization and step therapy, the drugs are not covered.
	Preferred brand non-Specialty drugs	Retail: \$30 copay Mail Order: \$60 copay	Not covered	
	Generic Specialty drugs	\$20 copay	Not covered	
	Preferred brand Specialty drugs	\$60 copay	Not covered	
	Insulin, syringes, and diabetic supplies	Retail copay applies to both Retail and Mail Order insulin, syringes, and diabetic supplies.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then \$100 copay per visit, then 10% of Allowed Benefit	Paid as in Network	Limited to Emergency Services or unexpected, urgently required services. For other services, you pay Deductible, then \$100 copay, the 50% of Allowed Benefit. Copay waived if admitted.
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	None
	Urgent care	\$30 copay per visit	Deductible, then 30% of Allowed Benefit	Limited to unexpected, urgently required services
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%.
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$30 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Office Visits & Hospital Facility: Deductible, then 30% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply.
	Inpatient services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Out-of-Network: Without prior authorization, the Allowed Benefit is reduced by 50%. Prior authorization is required; Additional professional charges may apply.
If you are pregnant	Office visits	No Charge	Deductible, then 30% of Allowed Benefit	"No Charge" applies to routine pre/postnatal visits only. For non-routine obstetrical care or complications during pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then 10% of Allowed Benefit	Deductible, then 50% of Allowed Benefit	Additional professional charges may apply.
If you need help recovering or have other special health needs	Home health care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Treatment plan must be approved before benefits will be paid. Benefits are limited to 20 visits per benefit period.
	Rehabilitation services	Office Visit: \$50 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	Benefits are limited to 25 visits per benefit period for each type of therapy (Occupational, Speech and Physical).
	Habilitation services	Office Visit: \$50 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits are limited to 25 visits per benefit period.
	Skilled nursing care	10% of Allowed Benefit	30% of Allowed Benefit	Out-of-Network Skilled Nursing Facility: Without prior authorization, the Allowed Benefit is reduced by 50%. Prior authorization is required. Benefits are limited to 60 days per benefit period. Admission must be within 14 days of a hospital confinement of at least 3 days.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Outpatient Private Duty Nursing: Prior authorization is required. Benefits are limited to 20 days per benefit period.
	Durable medical equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Inpatient & Outpatient Care: Deductible, then 10% of Allowed Benefit	Inpatient & Outpatient Care: Deductible, then 10% of Allowed Benefit	Prior authorization is required. Benefits are limited to 240 days per benefit period.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Hearing aids Infertility treatment Long-term care Routine eye care (Adult) Routine foot care 	<ul style="list-style-type: none"> Weight loss programs Non-surgical care for temporomandibular joint disorder (TMJ) (plan pays up to a lifetime max of \$600) 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> Chiropractic care (limited to 25 visits per benefit period) 	<ul style="list-style-type: none"> Coverage provided outside the US. See www.carefirst.com 	<ul style="list-style-type: none"> Private-duty nursing (limited to 20 days per benefit period) Non-emergency care when travelling outside the US 	

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$600
■ Specialist	\$50
■ Hospital (facility)	10%
■ Other	\$30

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$230
Coinsurance	\$920
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$1,760

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$600
■ Specialist	\$50
■ Hospital (facility)	10%
■ Other	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$1,020
Coinsurance	\$123
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,743

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$600
■ Specialist	\$50
■ Hospital (facility)	\$100
■ Other	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$400
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,030

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Perdue Farms Inc.

BluePreferred Option- ESS 20

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance make the Group Contract's terms and provisions binding on CareFirst and the Group.

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part. Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Individuals enrolled in the Plan are also covered by the Prescription Drug Program described in Appendix A. Appendix A is not part of the Evidence of Coverage or the Group Contract and is not administered by CareFirst—it is administered by Express Scripts. It is being provided together with this Evidence of Coverage solely for the convenience of the participants. As described more fully in the Evidence of Coverage, both covered medical expenses and covered prescription drug expenses count toward the Plan's deductibles and out-of-pocket maximums.

Group Name: **Perdue Farms Inc.**

Account
Number(s): **67088**

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. **Preferred Health Care Providers:** For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.
2. **Non-Preferred Health Care Providers:**
 - a. **Non-Preferred health care practitioner:** For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or CareFirst's established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.
 - b. **Non-Preferred hospital or health care facility:** For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or CareFirst's established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.
 - c. **Non-Preferred Emergency Services Health Care Provider:** CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:
 - 1) The Allowed Benefit stated in paragraphs 2.a., or 2.b.
 - 2) The amount negotiated with Preferred Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Preferred Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

- 3) The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Preferred Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.
- 4) The amount that would be paid under Medicare (part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

Adverse Decision means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: **January 1st** through **December 31st**.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of Eligible Members.

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member whereby CareFirst and the Member share in the payment for Covered Services.

Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that has contracted with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated in the Inter-Plan Ancillary Services section.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hooyer/stair lifts, ramps, shower/bath bench, items available without a prescription).

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one Copay.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

Deductible means the dollar amount of Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him/herself.

Dependent means a Member other than the Subscriber, meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained the Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment; or
6. Satisfaction of any combination of the above factors.

Designated Wellness Services Provider means a third-party service provider contracted by Group to provide specific wellness services to Members. For purposes of this Evidence of Coverage, the Group's Designated Wellness Services Provider is a Non-Preferred Provider. Services provided by the Group's Designated Wellness Services Provider are as defined by the Group. For description of such services please contact the Group directly.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage means this agreement, which includes the acceptance, riders and amendments, if any, between the Group and CareFirst (also referred to as the Group Contract).

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA means the U.S. Food and Drug Administration.

Group means the Subscriber's employer/Plan Sponsor or other organization to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the Group Contract includes any riders and/or amendments attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Habilitative Services means health care services and devices, including, but not limited to, Occupational Therapy, Physical Therapy, and Speech Therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

Infusion Therapy means treatment that places therapeutic agents into the vein, including intravenous feeding.

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

Limiting Age means the maximum age to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Director means a board-certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. Not primarily for the convenience of a patient or Health Care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

Member means an individual who meets all applicable eligibility requirements, is enrolled either as a Subscriber or Dependent, and for whom payment has been received by CareFirst.

Non-Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that does not contract with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated in the Inter-Plan Ancillary Services section.

Non-Preferred Health Care Provider means any Health Care Provider that is not a Preferred Provider.

Occupational Therapy means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

Paid Claims means the amount paid by CareFirst for Covered Services. Inter-Plan Arrangements Fees and Compensation are also included in Paid Claims. Other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator may also be included in Paid Claims.

Physical Therapy means the short-term treatment described below that can be expected to result in an improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan of Treatment means the plan written and given to CareFirst by the attending Health Care Provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The contracted Preferred Provider has the obligation of referring Members within the network. Preferred Provider relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.

A listing of Preferred Providers may be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any Health Care Provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means:

1. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription."
2. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
3. Prescription Drugs do not include:
 - a. Compounded bulk powders that contain ingredients that:
 - 1) Do not have FDA approval for the route of administration being compounded, or
 - 2) Have no clinical evidence demonstrating safety and efficacy, or
 - 3) Do not require a prescription to be dispensed.
 - b. Compounded drugs that are available as a similar commercially available Prescription Drug unless:
 - 1) There is no commercially available bio-equivalent Prescription Drug; or
 - 2) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Private Duty Nursing means Skilled Nursing Care that is not rendered in a hospital/Skilled Nursing Facility.

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Service Area means CareFirst's Service Area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members.

Skilled Nursing Care, depending on the place of service or benefit, means:

1. Inpatient hospital/facility or Skilled Nursing Facility:
 - a. Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
2. Skilled Nursing Care provided in the home:
 - a. Medically Necessary skilled care services performed by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).
 - b. Skilled Nursing Care home visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if the visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
 - c. Services of a home health aide, medical social worker or registered dietician performed under the supervision of a licensed professional (RN or LPN) nurse.
 - d. Skilled Nursing Care services in a Home Health Care setting must be based on a Plan of Treatment submitted by a Health Care Provider.
3. Outpatient Private Duty Nursing:
 - a. Medically Necessary skilled care services performed by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).
 - b. Skilled Nursing Care must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if the visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
 - c. Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.

Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition, absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist means a physician who is certified or trained in a specified field of medicine.

Specialty Drug means Prescription Drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns – requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy means the treatment of communication impairment and swallowing disorders. Speech Therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family except for Benefits for Members Entitled to Medicare (Medicare Complementary) in which case Type of Coverage means Individual coverage. Additional categories of coverage do not apply to Benefits for Members Entitled to Medicare. Each Medicare-eligible person, including a Medicare-eligible Dependent, will be enrolled in an Individual Type of Coverage category under the Group Contract.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

Waiting Period means the period of time that must pass before an employee or Dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

A. **Requirements for Coverage**

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

1. The individual elects coverage;
2. The individual is entitled to Medicare, if Medicare Complementary coverage applicable;
3. The Group accepts the individual's election and notifies CareFirst; and
4. Payments are made on behalf of the Member by the Group.

B. **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section B.1., and as stated in the Termination of Coverage section of the Evidence of Coverage.

When an Employee enrolls a Dependent in the Plan, the enrollment constitutes a representation by the Employee that the individual meets the definition of a Dependent and is eligible for the Plan, and that the Employee will provide evidence of eligibility on request. The enrollment also constitutes an acknowledgement by the Employee that the Plan is relying on the Employee's representation of eligibility in accepting the enrollment of the Dependent. If the Employee fails to provide evidence of eligibility when requested, that failure is evidence of fraud and material misrepresentation and the Plan may terminate coverage for the individual, which termination may be retroactive to the date as of which the individual first become ineligible.

1. **Open Enrollment Period**

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

- a. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
- b. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

2. **Newly Eligible Subscriber**

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period or a special enrollment period.

3. **Special Enrollment Periods**

Special enrollment is allowed for certain individuals in conjunction with: (1) a loss of other coverage, (2) the acquisition of certain Dependent beneficiaries or (3) losing eligibility for Medicaid or CHIP coverage, or gaining eligibility for premium assistance under Medicaid or CHIP. The Subscriber or individual seeking special enrollment must provide notice within the time period described in the Eligibility Schedule. Enrollment will be effective as stated in the Eligibility Schedule.

These special enrollment periods are not the same as Medicare special enrollment periods.

If only the Subscriber is eligible under this Evidence of Coverage and Dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

If retirees are eligible for coverage under this Evidence of Coverage, references to an employee shall be construed to include a retiree, except for references made in the context of special enrollment for certain individuals who lose coverage, as special enrollment for certain individuals who lose coverage is not applicable to retirees.

a. Special enrollment for certain individuals who lose coverage:

- 1) CareFirst will permit current employees and Dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
- 2) Individuals eligible for special enrollment.
 - a) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:
 - (1) The employee and the Dependents are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
 - (3) The employee satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - b) When Dependent loses coverage. A Dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:
 - (1) The Dependent and the employee are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and

- (3) The Dependent satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - (4) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph B.3.a.2)b), or the employee satisfies the criteria of paragraph B.3.a.2)a) of this section.
- 3) Conditions for special enrollment.
 - a) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph B.3.a.3)a) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:
 - (1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
 - (2) In the case of coverage offered through a health maintenance organization, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
 - (3) In the case of coverage offered through a health maintenance organization, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual; and
 - (4) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

- b) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.
 - c) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph B.3.a.3)a) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.
 - d) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)
- 4) Applying for special enrollment and effective date of coverage. The Group or CareFirst will allow an employee a period of at least thirty (30) days after an event described above to request enrollment (for the employee or the employee's Dependent).
- a) Coverage will begin no later than the first day of the first (1st) calendar month beginning after the date the Group or CareFirst receives the request for special enrollment.

- b. Special enrollment with respect to certain Dependent beneficiaries:
- 1) Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2), of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
 - 2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph B.3.a.2)a), b), c), d), e), or f) of this section.
 - a) Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption.
 - b) Spouse of a participant only. An individual is described in this paragraph if either:
 - (1) The individual becomes the spouse of a participant; or
 - (2) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.
 - c) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:
 - (1) The employee and the spouse become married; or
 - (2) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.
 - d) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.
 - e) Current employee and a new Dependent. A current employee and an individual who is a Dependent of the employee, are described in this paragraph if the individual becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.
 - f) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the Dependent becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.

- c. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

CareFirst will permit an employee or Dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

- 1) Termination of Medicaid or CHIP coverage. The employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.
- 2) Eligibility for employment assistance under Medicaid or CHIP. The employee or Dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

MEDICAL CHILD SUPPORT ORDERS

A. Definitions

1. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
 - a. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
 - b. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
2. Qualified Medical Support Order (QMSO) means a MCSO issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended.

B Eligibility and Termination

1. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage the child will not be enrolled until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.
2. Enrollment for such a child will not be denied because the child:
 - a. Was born out of wedlock.
 - b. Is not claimed as a Dependent on the Subscriber's federal tax return.
 - c. Does not reside with the Subscriber.
 - d. Is covered under any Medical Assistance or Medicaid program.

3. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
 - a. The MCSO/QMSO is no longer in effect;
 - b. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or
 - c. If coverage is provided under an employer sponsored health plan;
 - 1) The employer has eliminated family member's coverage for all employees; or
 - 2) The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable state or federal law, the child will continue in this post-employment coverage.

C. **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

1. Send the non-insuring custodial parent ID cards, claims forms, the applicable evidence of coverage or member contract and any information needed to obtain benefits;
2. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
3. Provide benefits directly to:
 - a. The non-insuring parent;
 - b. The Health Care Provider of the Covered Services; or
 - c. The appropriate child support enforcement agency of any state or the District of Columbia.

TERMINATION OF COVERAGE

A. Disenrollment of Individual Members

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons:

1. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.
2. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.
3. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.
4. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.
5. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.
6. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

B. Death of a Subscriber

If Dependent coverage is available, in the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

C. Effect of Termination

No benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

D. Reinstatement

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

A. Continuation of Eligibility upon Loss of Group Coverage

1. **Federal Continuation of Coverage under COBRA**

If the Group health benefit Plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit Plan may be possible. The employer offering this Group health benefit Plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the Plan Administrator.

2. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

COORDINATION OF BENEFITS; SUBROGATION

A. Coordination of Benefits

1. Applicability

- a. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
- b. If this COB provision applies, the Order of Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
 - 1) Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; and
 - 2) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is explained in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

2. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Evidence of Coverage.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

- a. An individually underwritten and issued, guaranteed renewable, specified disease policy, or specified accident policy;
- b. An intensive care policy, which does not provide benefits on an expense incurred basis;
- c. Coverage regulated by a motor vehicle reparation law;
- d. Any hospital indemnity or other fixed indemnity coverage contract;
- e. An elementary and/or secondary school insurance program sponsored by a school or school system and any school accident-type coverage that covers for accidents only, including athletics injuries;
- f. Medicare supplemental policies;
- g. Limited benefit health coverage as defined by state law;
- h. Long-term care insurance policies for non-medical services;
- i. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.
- j. A state plan under Medicaid; or
- k. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

- a. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- b. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- c. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

3. **Order of Benefit Determination Rules**

a. **General**

When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- 1) The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
- 2) Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

b. **Rules**

This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

- 1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- a) Secondary to the Plan covering the person as a Dependent; and
- b) Primary to the Plan covering the person as other than a Dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering the person as other than a Dependent.

- 2) Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a Dependent, the order of benefits shall be determined as follows:

- a) For a Dependent child whose parents are married or are living together:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - (2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

b) For a Dependent child whose parents are separated, divorced, or are not living together:

- (1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but the parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in 3.b.2)a) above also shall apply if: i) a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the Dependent child.

- (2) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- (a) The Plan of the parent with custody of the child;
- (b) The Plan of the spouse of the parent with the custody of the child;
- (c) The Plan of the parent not having custody of the child; and then
- (d) The Plan of the spouse of the parent who does not have custody of the child.

c) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in a) and b) of this paragraph as if those individuals were parents of the child.

- 3) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a Dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

- 4) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:
 - a) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's Dependent);
 - b) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 5) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

4. **Effect on the Benefits of this CareFirst Plan**

a. **When this Section Applies**

This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

b. **Reduction in this CareFirst Plan's Benefits**

When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

5. **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.

6. **Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

7. **Right of Recovery**

If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

B. **Employer or Governmental Benefits**

Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
2. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

C. **Subrogation**

1. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:
 - a. Caused by an act or omission of a third party; or
 - b. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or
 - c. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose. CareFirst will not subrogate a recovery made under Personal Injury Protection policy benefits.
2. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Evidence of Coverage, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid in benefits up to the amount received from or on behalf of the third party. CareFirst will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.

3. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.
4. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

For purposes of this provision, "made whole" means that the Member fully recovers all of their damages.

5. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Evidence of Coverage. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.
6. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in the “Choosing a Provider” subsection below. Other factors that may affect payment are found in Referrals, COB, Subrogation, the Inter-Plan Arrangements Disclosure, Inter-Plan Programs Ancillary Services, Exclusions, and Utilization Management Requirements.

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

- a. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider contracts with CareFirst or not relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.
- b. CareFirst makes payment for Covered Services but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Preferred Health Care Providers

- a. If a Member chooses a Preferred Health Care Provider, the cost to the Member is lower than if the Member chooses a Non-Preferred Health Care Provider. Throughout the Schedule of Benefits, payments are listed as either “in-network” (for a Preferred Health Care Provider) or “out-of-network” (for a Non-Preferred Health Care Provider).

If a Preferred Health Care Provider refers a Member to a Non-Preferred Health Care Provider, CareFirst will pay the in-network benefit, but the Member will still be responsible for the difference between CareFirst’s payment and the Non-Preferred Health Care Provider’s charge.

- b. Claims will be submitted directly to CareFirst by the Preferred Health Care Provider.
- c. CareFirst will pay benefits directly to the Preferred Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.
- d. The Member is responsible for any applicable Deductible and Coinsurance or Copayment, as stated in the Schedule of Benefits.

3. Non-Preferred Health Care Providers
 Except as otherwise authorized by CareFirst, if a Member chooses a Non-Preferred Health Care Provider, Covered Services may be eligible for reduced benefits. When Covered Services are provided by a Non-Preferred Health Care Provider, out-of-network benefits apply.
 - a. Claims may be submitted directly to CareFirst or its designee by the Non-Preferred Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
 - b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Preferred Health Care Provider, at the discretion of CareFirst.
 - c. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the appropriate department of an appropriate State (as designated in the order or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.
 - d. Non-Preferred Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Preferred Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Member is responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.
4. Ambulance Services Providers
 - a. For purposes of calculating the Member payment for Ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide	
If a Member receives Covered Services from:	Member liability:
Preferred Ambulance Services Provider	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Ambulance Services Provider	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Ambulance Services Provider's actual charge.

- b. If a Member receives services from a Preferred Provider, the cost to the Member is lower than if the Member receives services from a Non-Preferred Provider.

C. Notice of Claim

A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

D. Claim Forms

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

E. Proofs of Loss

In order to receive benefits for services rendered by a Health Care Provider who does **not** contract with CareFirst, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

1. Claims for medical benefits must be submitted within twelve (12) months following the dates services were rendered.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the member, not later than one year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

F. Time of Payment of Claims

Benefits payable under this Evidence of Coverage will be paid not more than thirty (30) days after receipt of written proof of loss.

G. Claim Payments Made in Error

If CareFirst makes a claim payment to or on behalf of a Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

H. Assignment of Benefits

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Preferred Health Care Provider rendering Covered Services. A Member may not assign his or her right to bring a lawsuit under ERISA against Perdue, the Plan, the Plan Administrator, or CareFirst.

I. Evidence of Coverage

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable. Only one statement will be issued for each family unit.

J. Notices

Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail or by first class mail to the most recent address for the Member in CareFirst's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

K. **Privacy Statement**

CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

L. **Prescription Drug Rebate Sharing**

CareFirst may be eligible for rebates from Prescription drug manufacturers upon negotiating directly with manufacturers.

CareFirst and the Plan Sponsor, as such is defined in the Administrative Services Agreement, agree to the extent to which any such rebates are shared.

REFERRALS

Referral Requirements

- A. Written referrals are not required.
- B. Referral to a Specialist or Non-Physician Specialist
1. Non-Physician Specialist means a Health Care Provider who is not a physician who is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any state or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.
 2. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and
 - a. CareFirst does not contract with a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
 - b. CareFirst cannot provide reasonable access to a contracted specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
 3. For purposes of calculating any Member payment, CareFirst will treat the services provided by the Specialist or Non-Physician Specialist as if the services were provided by a Preferred Health Care Provider.
- C. Referrals Quick Reference

While written referrals are not required, Covered Services with a referral will be available as follows:

For Covered Services:			
If a Member sees a:	With referral:	Without referral:	Member liability:
Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.		No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.	Covered Services will be paid at the out-of-network level of benefits if out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted for Covered Services: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits and for the difference between the Allowed Benefit and the Non-Preferred Health Provider's actual charge.

This Referrals Quick Reference guide is subject to the terms stated in the Referral to a Specialist or Non-Physician Specialist section, above.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

Most Prescription Drugs classified as Specialty Drugs require prior authorization; prior authorization applies to Specialty Drugs covered under the medical portion of this Evidence of Coverage (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings). Specialty Drugs are defined in the Definitions section of this Evidence of Coverage. Preferred Health Care Providers will obtain prior authorization from CareFirst on behalf of the Member. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization/a Plan of Treatment. Failure to obtain prior authorization may result in denial of the claim.

A. Plan of Treatment

Certain outpatient services indicated throughout this Evidence of Coverage require CareFirst's approval of a Plan of Treatment before benefits for Covered Services are provided; a penalty may apply if such approval is not obtained.

1. A health care practitioner must complete and submit a Plan of Treatment.
2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.
3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.
4. Within the Service Area, a Preferred Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Preferred Health Care Provider or a Non-Preferred Health Care Provider.
5. Services for which CareFirst must approve a Plan of Treatment:
 - a. Controlled Clinical Trial Patient Cost coverage

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
 - b. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

c. Home Health Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late (forty-eight (48) hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

d. Hospice Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing hospice care, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

e. Private Duty Nursing

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

B. Hospital Pre-Certification and Review

A Preferred Health Care Provider, in and out of the Service Area, will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Preferred Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

- a. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.
- b. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.
- c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.
- d. Pre-operative days will not be approved for procedures unless Medically Necessary.
- e. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.
- f. CareFirst's payment will be based on the inpatient days approved by the reviewer.
- g. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.

- h. Hospital Pre-Certification and Review is not applicable to maternity admissions, and admissions for cornea and kidney transplants.
2. Non-Emergency (Elective) Admissions
- a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.
 - b. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.
 - c. CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - d. For Out-of-Network Covered Services:
 - 1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.
3. Emergency (Non-Elective) Admissions
- a. The Member, the Health Care Provider or another person acting on behalf of the Member must notify the reviewer within twenty-four (24) hours following the Member's admission, or as soon thereafter as reasonably possible.
- The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify the reviewer of the emergency admission within twenty-four (24) hours if the Member's medical condition prevented the hospital from determining:
- 1) The Member's insurance status; and
 - 2) The reviewer's emergency admission notification requirements.
- b. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:
 - 1) During the first twenty-four (24) hours the Member is in an inpatient facility; or
 - 2) Until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a Member has been admitted and shall state the reasons for the admission.

- c. The reviewer will make all initial determinations on whether to approve a non-elective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

For non-elective admissions for which the reviewer receives notice but does not approve inpatient benefits, CareFirst will notify the hospital attending Health Care Provider that inpatient benefits will not be paid as of the date of notification.

- 1) A Member will have to pay:
 - a) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.
 - b) Non-Preferred Health Care Providers if a non-elective admission results in payment denial.
- 2) A Member will not have to pay Preferred Providers:
 - a) If the Member is admitted and the admission is not Medically Necessary;
 - b) If a non-elective admission results in payment denial.

- d. For Out-of-Network Covered Services:

- 1) CareFirst will not provide benefits for a non-elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
- 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the non-elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by;
 - b) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

4. Continued Stay Review
The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.
5. Discharge Planning
The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.

6. Program Monitoring
 - a. The Member's medical record will be reviewed by the reviewer.
 - b. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.
 - c. During and after discharge, the reviewer may review the medical records to:
 - 1) Verify that the services are covered under the Evidence of Coverage;
 - 2) Ensure that the Health Care Provider is substantially following the Plan of Treatment.
7. Notice and Appeals
 - a. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.
 - b. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.
 - 1) If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.
 - 2) For instructions on how to appeal an Adverse Decision, refer to the Claims Procedures of this Evidence of Coverage.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services

Overview

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan. The Inter-Plan Programs are described generally below.

When a Member receives care outside of CareFirst’s service area, it will be received from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. CareFirst explains below how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst’s service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst’s service area and care received outside the geographic area CareFirst serves is stated in the Definitions.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when a Member receives Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When a Member receives Covered Services outside CareFirst’s service area and the claim is processed through the BlueCard Program, the amount a Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount a Member pays for Covered Services under this arrangement will be calculated based on the negotiated price/lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to a Member, the Member will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, a Member will incur no liability, other than any related Member cost sharing.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside CareFirst's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount a Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, a Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

E. **Blue Cross Blue Shield Global Core Program**

If a Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), the Member may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit Member claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **Members must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Members pay for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submission, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs); and
2. Medical Devices and Supplies.

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider or a Health Care Provider who contracts with the local Blue Cross and/or Blue Shield Licensee in that geographic area as stated in the Inter-Plan Arrangements Disclosure.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: <ul style="list-style-type: none">• Shipped to; or• Purchased at a retail store.	

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE (Medicare Complementary)

The provisions in this section apply to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in this Evidence of Coverage. Benefits that are covered by Medicare are subject to the provisions in this section.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures; however, the Utilization Management Requirements of this Evidence of Coverage do not apply to persons for whom Medicare is the primary carrier.

Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Providers contracted with CareFirst, all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

This coverage is not Medicare supplemental coverage. This coverage provides benefits for some charges and services not covered by Medicare. It is not designed to fill the "gaps" of Medicare.

Covered Services under Medicare Complementary are the same as under the Description of Covered Services. Only the manner of payment is different:

A. Coverage Secondary to Medicare

Except where prohibited by law, CareFirst benefits are secondary to Medicare.

B. Medicare as Primary

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare:
 - a. For any Health Care Provider who accepts Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge.
 - b. For any Health Care Provider who does not accept Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the limitation set by Medicare.
2. **For a Member who Elects Medicare Part B:** CareFirst will coordinate as described above and pay benefits based on Medicare's payment. For example, after meeting the Part B deductible, Medicare pays 80% of the Medicare approved amount for most doctor services; the basis for CareFirst's payment is the remaining 20% of the Medicare approved amount (the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge/limitation set by Medicare).

- a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming:	
Part B deductible has been met; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%; and Medicare approved charge does not exceed limitation set by Medicare, if applicable	
Medicare approved amount	\$ 1,000.00
Multiplied by 80% equals Medicare payment	\$ 800.00
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

3. **For a Member who Does not Elect Part B:** CareFirst will reduce its payment to “carve-out” or reject the 80% coinsurance Medicare would have paid if the Member had elected Part B.
- a. If the amount Medicare would have paid is available, CareFirst will coordinate as described above, “carving-out” or rejecting the amount Medicare would have paid. CareFirst will base its reduced Coinsurance payment on the amount Medicare would have paid if the Member had elected Part B.
- b. If the amount Medicare would have paid is not available, CareFirst will base its Coinsurance payment on 20% of the Allowed Benefit. The 80% reduction to the Allowed Benefit represents the amount that Medicare theoretically would have paid if the Member had elected Part B.
- c. Numerical Examples for a Member who Does not Elect Part B:
- 1) In the first numeric example below, CareFirst's Allowed Benefit is assumed to be the same as the Medicare approved amount in the above example for a Member who elects Medicare Part B. In this example, CareFirst's payment does not differ; however, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 1,000.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

- 2) In the second numeric example below, CareFirst's Allowed Benefit is assumed to differ from the Medicare approved amount in the above example for a Member who elects Medicare Part B. Again, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 500.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 100.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 100.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 80.00

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists other features that affect Member coverage, including, if applicable, the Deductible, Out-of-Pocket Maximum, and specific benefit limitations. It is also important to review the section entitled "Exclusions."

PREVENTIVE AND WELLNESS SERVICES

A. Covered Services:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
 - a. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.
 - b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.
 - c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
2. If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.
3. CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

**AMBULANCE SERVICES
(NON-EMERGENCY)**

A. Covered Services

1. Medically Necessary, non-emergency air transportation, surface, and ground ambulance services, as determined by CareFirst.

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Is approved by:
 - a. The National Institutes of Health (NIH) or a Cooperative Group.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - 1) To be comparable to the system of peer review of studies and investigations used by the NIH, and
 - 2) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - h. The FDA in the form of an investigational new drug application.
 - i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Evidence of Coverage for non-Investigational treatments.

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:
 - a. Treatment provided for a life-threatening condition; or,
 - b. Prevention, early detection, and treatment studies on cancer.
2. Coverage will be provided only if:
 - a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer; or,
 - b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;
 - c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,
 - e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.
 - f. Prior authorization has been obtained from CareFirst.
3. Coverage is provided for the Patient Cost, including Patient Cost, incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

DIABETES EQUIPMENT

Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

DIABETES SUPPLIES

Coverage will be provided for all Medically Necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

DIABETES SELF-MANAGEMENT TRAINING

1. Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
2. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

1. With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the Member.
2. Medically Necessary, emergency air transportation, surface, and ground ambulance services, as determined by CareFirst.
3. Urgent Care services.

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:
 - a. If the Member is:
 - 1) Seven years of age or younger, or developmentally disabled;
 - 2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and
 - 3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - b. Or, if the Member is:
 - 1) Seventeen years of age or younger;
 - 2) An extremely uncooperative, fearful, or uncommunicative individual;
 - 3) An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - 4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - c. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - d. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - 1) A fully accredited specialist in pediatric dentistry;
 - 2) A fully accredited specialist in oral and maxillofacial surgery; and
 - 3) A dentist who has been granted hospital privileges.
 - e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

HOME HEALTH CARE

A. Definitions

Home Health Care means the continued care and treatment of a Member by a Health Care Provider in the home if:

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and
2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

Home Health Care Visits means:

1. Each visit by a member of a Home Health Care team is considered one Home Health Care Visit; and
2. Up to four (4) hours of Home Health Care service is considered one Home Health Care visit.

B. Covered Services

1. Home Health Care, as defined above.
2. Home Visits Following Childbirth, including any services required by the attending Health Care Provider:
 - a. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or ninety-six (96) hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;
 - b. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):
 - 1) One home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge;
 - 2) An additional home visit following childbirth if prescribed by the attending Health Care Provider.
 - c. An attending Health Care Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Health Care Provider, attending the Member or newborn Dependent child(ren).
 - d. Home visits following childbirth must be rendered, as follows:
 - 1) In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
 - 2) By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

3. Home Visits Following the Surgical Removal of a Testicle
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - 1) One home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and
 - 2) An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

C. Limitations

1. The Member must be confined to “home” due to a medical condition. “Home” cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.
2. The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. “Skilled Nursing Care,” for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.
4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).
5. See additional limitations in the Schedule of Benefits.

HOSPICE CARE

A. Definitions

Caregiver means a person who is not a Health Care Provider who lives with or is the primary caregiver of the Member in the home. The Caregiver can be a relative by blood, marriage or adoption or a friend of the Member, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

1. Inpatient hospice facility services;
2. Part-time nursing care by or supervised by a registered graduate nurse;
3. Counseling, including dietary counseling, for the Member;
4. Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the Member;
5. Medical care by the attending physician;
6. Other Medically Necessary health care services at CareFirst's discretion.

Additionally, hospice care benefits are available for a Member's family (family is the spouse, parents, siblings, grandparents, child(ren), and/or Caregiver) for periodic family counseling before the Member's death, and bereavement counseling.

A Member, or representative of the Member, can petition CareFirst to review the Member's case and authorize an extension of coverage. CareFirst reserves the right to extend the hospice care eligibility period for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care, if it determines that the patient's prognosis and continued need for services are consistent with a program of hospice care. Additional "reserve" benefits (up to 45 days) apply if the Member exceeds: the Hospice Eligibility Period and/or the inpatient benefit limit.

INFERTILITY SERVICES

A. Definitions

Infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.

B. Covered Services

1. Benefits are available for the diagnosis of Infertility excluding artificial insemination/intrauterine insemination and in vitro fertilization.
2. Under the Prescription Drug Coverage (see APPENDIX A), benefits are available for fertility drugs, up to a lifetime maximum of \$10,000. Benefits are not otherwise available for the treatment of Infertility.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(ambulatory services; hospitalization; laboratory services)

A. Covered Services

1. Inpatient/outpatient medical care and consultations.

Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Health Care Provider and a Member. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

2. Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

3. Surgery, as follows:

a. Oral surgery, limited to:

- 1) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity not solely involving teeth.
- 2) Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

- 1) The injury did not arise while or as a result of biting or chewing; and
- 2) Treatment is commenced within twelve (12) months of the injury or, if due to the nature of the injury treatment could not begin within twelve (12) months of the injury, treatment began within twelve (12) months of the earliest date that it would be medically appropriate to begin such treatment.

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

- b. Medically Necessary surgical procedures, as determined by CareFirst.

If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

- 1) If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.
- 2) If the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

- c. Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are (i) Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention, or (ii) described in the following section, entitled "Mastectomy Related Services.

- 4. Inpatient/outpatient assistant if the surgery requires surgical assistance as determined by CareFirst.
- 5. Inpatient/outpatient anesthesia services by a Health Care Provider other than the operating surgeon.
- 6. Inpatient/outpatient chemotherapy.
- 7. Home Infusion Therapy.
- 8. Inpatient/outpatient radiation therapy.
- 9. Inpatient/outpatient renal dialysis.
- 10. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
- 11. Administration of injectable Prescription Drugs by a Health Care Provider.
- 12. Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), allergy testing.
- 13. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.

14. Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from oral surgery, and otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.
15. Elective sterilization.
16. Skilled Nursing Facility services.
17. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
18. Treatment of temporomandibular joint (TMJ) dysfunction: Medically Necessary conservative treatment and surgery, as determined by CareFirst.
19. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
2. Breast prostheses prescribed by a physician for a Member who has undergone a mastectomy and has not had breast reconstruction;
3. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member;
4. Inpatient hospital services for a minimum of forty-eight (48) hours following a mastectomy as a result of breast cancer. A Member may request a shorter length of stay if the Member decides, in consultation with the attending physician, that less time is needed for recovery.
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - 1) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
 - 2) An additional home visit if prescribed by the Member's attending physician.
 - b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician.

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services, including:

a. Maternity services:

- 1) Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:
 - a) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support, supplies and consultation as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration; and
 - b) Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration.
- 2) Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not specifically identified above, and Ancillary Services provided during those visits. These benefits include Medically Necessary laboratory diagnostic tests and services not identified above, but are not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
- 3) Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event.

b. Newborn care services, as follows:

- 1) Medically Necessary services for the normal newborn (an infant born at approximately forty (40) weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
- 2) Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;
- 3) Circumcision.

- c. Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - 1) A minimum of:
 - a) Forty-eight (48) hours following an uncomplicated vaginal delivery;
 - b) Ninety-six (96) hours following an uncomplicated cesarean section.
 - 2) Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.
- 3. Coverage for victims of rape or incest.
- 4. Birthing classes: One (1) course per pregnancy at a CareFirst approved facility.
- 5. Birthing centers.
- 6. Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
- 7. Benefits are available for comprehensive lactation support and counseling, by a Health Care Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

1. Is primarily and customarily used to serve a medical purpose;
2. Is not useful to a person in the absence of illness or injury;
3. Is ordered or prescribed by a physician or other qualified practitioner;
4. Is consistent with the diagnosis;
5. Is appropriate for use in the home;
6. Is reusable; and
7. Can withstand repeated use.

Medical Device means Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

1. Are primarily and customarily used to serve a medical purpose;
2. Are not useful to a person in the absence of illness or injury;
3. Are ordered or prescribed by a physician or other qualified practitioner;
4. Are consistent with the diagnosis;
5. Are appropriate for use in the home;
6. Cannot withstand repeated use; and
7. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
4. May be purely passive support or may make use of spring devices;
5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a Health Care Provider; and
5. Is removable and attached externally to the body.

B. Covered Services

1. **Durable Medical Equipment**

Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

2. **Hair Prosthesis**

Benefits are available for a hair prosthesis for treatment of cancer.

3. **Medical foods and nutritional substances**

Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

4. **Medical Supplies**

Benefits are available for Medical Supplies as such supplies are defined above.

5. **Orthotic Devices, Prosthetic Devices**

Benefits include:

- a. Supplies and accessories necessary for effective functioning of the Orthotic or Prosthetic Device;
- b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
- c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.
- d. **Repairs.** Benefits for the repair, maintenance or replacement of an Orthotic or Prosthetic Device require authorization or approval by CareFirst. Benefits are

limited to:

- 1) Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
- 2) Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.
- 3) Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

**MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES,
INCLUDING BEHAVIORAL HEALTH TREATMENT**

Inpatient/outpatient mental health and substance use disorder services, including behavioral health treatment.

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

Donor Services consist of services covered under the Evidence of Coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Recipient/Donor Services

When Member is a:	Benefits are available for:
Recipient	Benefits are available for both the Member recipient and the non-Member donor. Donor benefits are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services.

Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/ Investigational as determined by CareFirst.
2. Donor Services, limited to the extent stated above.
3. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.
4. Immunosuppressant maintenance drugs when prescribed for a covered transplant.
5. Organ transplant procurement benefits for the recipient, as follows:
 - a. Health services and supplies used by the surgical team to remove the donor organ.
 - b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.
 - c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
6. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;
2. Conform to all laws that apply to organ transplants; and
3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;
2. Diagnosis;
3. Type of surgery; and
4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

Benefits are available for Medically Necessary outpatient Private Duty Nursing, as determined by CareFirst. Benefits are not provided for Private Duty Nursing rendered in a hospital.

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
<p>Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs.</p> <p>Benefits are available through Express Scripts for Pharmacy-dispensed Prescription Drugs. Please see Appendix A at the end of this Evidence of Coverage for a description of the Prescription Drug Program.</p>	<p>Benefits are available, and limited to, Prescription Drugs dispensed in the office of a Health Care Provider.</p> <p>Contraceptives: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.</p>

PROFESSIONAL NUTRITIONAL COUNSELING/MEDICAL NUTRITION THERAPY

A. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

B. Covered Services

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

REHABILITATIVE AND HABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**

Benefits are available for inpatient Rehabilitative Services.

2. **Outpatient Rehabilitative Services**

Benefits are available for the following outpatient Rehabilitative Services:

a. Occupational Therapy;

b. Physical Therapy; and

c. Speech Therapy.

3. **Cardiac Rehabilitation**

Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation.

Benefits will not be provided for maintenance programs.

4. **Habilitative Services**

Benefits are available for outpatient Habilitative Services.

5. **Pulmonary Rehabilitation**

Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation.

Benefits will not be provided for maintenance programs.

6. **Visual Therapy**

Benefits are available for outpatient visual therapy.

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Preferred Health Care Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
 2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
 3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including: flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
 - Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
 - Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).
 - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
 - All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the Member, unless otherwise a Covered Service.

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.
- Any procedure or treatment designed to alter an individual’s physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to health education classes and self-help programs, except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary and/or cardiac rehabilitation programs and services provided by the Group’s Designated Wellness Services Provider.
- Medical or surgical treatment for obesity, unless otherwise specified in the Description of Covered Services.
- Medical or surgical treatment or regimen for reducing or controlling weight for morbid obesity.

These exclusions do not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.

- Routine vision examinations, including but not limited to external examination of the eye and adnexa, ophthalmoscopic examination, determination of refractive status, binocular balancing testing, tonometry test for glaucoma, gross visual field testing, and color vision testing.
- Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses.
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.
- Non-medical Health Care Provider services, including, but not limited to:
 1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
 2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider’s medical practices services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.

- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.
- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).
- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.

- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.
- Immunizations solely for foreign travel.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in the Description of Covered Services.
- Hearing care except as otherwise stated.
- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.
- Work Hardening Programs. Work Hardening Programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

Ambulance (Non-Emergency) Services

- Except Medically Necessary, non-emergency ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

Emergency Services

- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

General anesthesia and associated hospital or ambulatory surgical facility services for dental care

- Dental care for which general anesthesia is provided.

Home Health Care

- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.
- Respite care.

Infertility Services

- Medical or surgical treatment for Infertility, except as stated in the Description of Covered Services.

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.
- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.
- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).
- Acupuncture.
- Inpatient Private Duty Nursing.
- Procedures to reverse sterilization.
- Surgical removal of impacted teeth.
- Elective Abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother or expenses are incurred to treat medical complications due to the abortion or the pregnancy is the result of rape or incest.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Medical Supplies, except as stated in the Description of Covered Services, or any riders attached to this Evidence of Coverage.
- Orthotic Devices and Prosthetic Devices, except as stated in the Description of Covered Services.
- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

Mental health and substance use disorder services, including behavioral health treatment

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses Incurred for the location of a suitable donor; e.g., search of a population or mass screening.

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services or Appendix A.
- Routine immunizations and boosters (except as stated in the Description of Covered Services, Preventive and Wellness Services).

Rehabilitative and Habilitative Services

- Services delivered through early intervention and school services.
- Applied Behavioral Analysis services.

ELIGIBILITY SCHEDULE

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group.	
Spouse	Coverage for a Dependent spouse is available.	
Domestic Partner	Coverage for Domestic Partners is not available.	
Dependent children	Coverage for Dependent children, excluding children of a Domestic Partner, is available.	Limiting Age Up to age 26
Unmarried, incapacitated Dependent children	<p>A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:</p> <ol style="list-style-type: none"> 1. The Dependent child is chiefly Dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty (30) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated. 	Limiting Age Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES OF COVERAGE	
Open Enrollment	The Group's Contract Date is the effective date of Coverage.
Newly eligible Subscriber	<p>A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.</p> <p>A Subscriber who is not enrolled when the Group receives a QMSO is eligible for coverage effective on the date specified in the MCSO.</p>
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Newly eligible Dependents of a Subscriber	<p>1. For a newborn Dependent, newly adopted Dependent child, newly eligible Dependent child, a minor Dependent child for whom Guardianship is granted by Court or Testamentary Appointment, coverage is effective as follows:</p> <ol style="list-style-type: none"> If the Subscriber's Type of Coverage is "Family" Type of Coverage on the Dependent child's First Eligibility Date, the Dependent child will be covered automatically effective as of the child's First Eligibility Date, stated below. If the Subscriber's Type of Coverage is "Individual" Type of Coverage as of the Dependent child's First Eligibility Date stated below, the Dependent child will be covered automatically <u>only</u> for the first thirty-one (31) days following the Dependent child's First Eligibility Date. However, if the Subscriber wishes to continue the child's coverage beyond the automatic thirty-one (31) day period, the Subscriber must enroll the Dependent child within thirty-one (31) days of the child's First Eligibility Date. If the Subscriber's Type of Coverage is "Individual and Adult" or "Individual and child" Type of Coverage as of the Dependent child's First Eligibility Date stated below, the Dependent child will be covered automatically as of the Dependent child's First Eligibility Date. However, if the addition of the Dependent child results in a change in the Subscriber's Type of Coverage (e.g., from "Individual and Adult" or "Individual and Child" coverage to "Family" coverage), the Dependent child's automatic coverage will end on the thirty-first (31st) day following the child's First Eligibility Date. If the Subscriber wishes to continue coverage beyond the automatic thirty-one (31) day period, the Subscriber must enroll the Dependent child within thirty-one (31) days following the First Eligibility Date. "First Eligibility Date" means: <ol style="list-style-type: none"> For a newborn Dependent child, the child's date of birth. For a newly adopted Dependent child, the earlier of: <ol style="list-style-type: none"> A judicial decree of adoption; or Placement of the Dependent child in the Subscriber's home as the legally recognized proposed adoptive parent. For newly eligible Dependent child, the date the Dependent child became a Dependent of Subscriber or the Subscriber's Dependent spouse. For a minor Dependent child for whom guardianship has been granted by court or testamentary appointment the date of the appointment.

EFFECTIVE DATES OF COVERAGE	
	2. All other newly eligible Dependents of a Subscriber must apply for coverage under this Evidence of Coverage as stated in the Special Enrollment Periods section of this Eligibility Schedule. Coverage for such newly eligible Dependents will be effective as stated in the Special Enrollment Periods section of this schedule.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage	<p>The employee must notify the Group, and the Group must notify CareFirst no later than thirty (30) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.</p>
Special enrollment for certain Dependent beneficiaries	<p>The employee must notify the Group, and the Group must notify CareFirst during the thirty (30) day special enrollment period beginning, as follows:</p> <p>In the case of marriage: the date of marriage (or, if Dependent coverage is not generally available at the time of the marriage, a period of thirty (30) days after Dependent coverage is made generally available by the Group).</p> <p>In the case of a newborn Dependent, newly adopted Dependent child, newly eligible Dependent child, a minor Dependent child for whom Guardianship is granted by Court or Testamentary Appointment: the enrollment period will be effective as stated in the Effective Dates of Coverage section of this schedule.</p>
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or Dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or Dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).</p> <p>A new Subscriber and/or his/her Dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.</p>

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the date eligibility ceases as determined by the Group.
Dependent child	<p>If the Subscriber enrolled the Dependent child within thirty-one (31) days of the child's First Eligibility Date:</p> <p>The Dependent child will remain covered until the birthday when the Dependent child reaches the Limiting Age for a Dependent child.</p> <p>If the Subscriber did not enroll the Dependent child within thirty-one (31) days of the child's First Eligibility Date:</p> <p>The Dependent child will remain covered until the end of the thirty-first (31st) day following the Dependent child's First Eligibility Date, as such is stated in the Effective Dates of Coverage section of this schedule.</p>
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the date eligibility ceases as determined by the Group.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.
Subscriber changes the Type of Coverage to an Individual or other non-family contract (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Coverage will terminate on the date the Subscriber changes the Type of Coverage to an Individual or other non-family contract.
Death of a Subscriber	Coverage of any Dependents will terminate on the date determined by the Group.

SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced. See Utilization Management Requirements for these rules.

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

DEDUCTIBLE			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$1,200	\$2,400	\$2,400	\$4,800
Applicable to all in-network benefits, except as stated in the Description of Covered Services.		Applicable to all out-of-network benefits, except as stated in the Description of Covered Services.	
In-Network and Out-of-Network			
The in-network and out-of-network Deductible will be a combined amount.			
The Deductible is calculated based on the Allowed Benefit of Covered Services.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Deductible, then for the remainder of the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Deductible and the Family Deductible apply. If the Family Deductible has not been met for the Benefit Period, then a Member must meet the Individual Deductible before CareFirst will pay the benefit amounts specified in the Schedule of Benefits for that Member. If the Family Deductible has been met for the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits for all covered family Members.			
The following amounts apply to the Deductible:		The following amounts may <u>not</u> be used to satisfy the Deductible:	
- 100% of the Allowed Benefit for Covered Services that are subject to the Deductible.		- Charges in excess of the Allowed Benefit. - Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below. - Charges for Covered Services not subject to the Deductible. - Amounts paid by the Members for the Covered Services provided under the Pharmacy-dispensed Prescription Drugs as provided in Appendix A.	

OUT-OF-POCKET MAXIMUM			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$6,000	\$12,000	\$12,000	\$24,000
In-Network and Out-of-Network			
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for the remainder of the Benefit Period.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum apply. If a covered family Member has met the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for that Member for the remainder of the Benefit Period. If a covered family Member has not met the Individual Out-of-Pocket Maximum, but the family as a whole has met the Family Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for all covered family Members for the remainder of the Benefit Period.			
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.			
The following amounts apply to the Out-of-Pocket Maximum:		The following amounts do <u>not</u> apply to the Out-of-Pocket Maximum:	
<ul style="list-style-type: none"> Coinsurance (Member's share). Copays. Deductible. Amounts paid by the Members for the Covered Services provided under the Pharmacy-dispensed Prescription Drugs as provided in Appendix A. 		<ul style="list-style-type: none"> Charges in excess of the Allowed Benefit. 	

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are not Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

IMPORTANT NOTE REGARDING THE ALLOWED BENEFIT FOR CERTAIN PROVIDERS
The Allowed Benefit for Covered Services will be the provider's actual charge for the following Health Care Providers:
<ul style="list-style-type: none"> Perdue Wellness Center Providers Omada Health Providers

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	60% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office		
Adult preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	60% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office		
Chlamydia screening		
Colorectal cancer screening		
Hepatitis C screening		
Human papillomavirus screening		
Mammography/breast cancer screening		
Osteoporosis prevention		
Prostate cancer screening		
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services	Limitations Ambulance services are limited, as follows: <ul style="list-style-type: none"> Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance. 	
Ambulance Services	80% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Limitations Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes equipment	80% of Allowed Benefit	60% of Allowed Benefit
Diabetes supplies		
Diabetes self-management training	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services		
Emergency Services in a hospital emergency room/department		
Hospital emergency room/department and ancillary services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	80% of Allowed Benefit after \$100 Copay*	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Outpatient professional practitioner(s) in hospital emergency room/department	80% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Member admitted as inpatient	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Hospital emergency room/department services for any condition that is not an Emergency Medical Condition	Please see “Medical care and consultations (illness visits)” table below.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay**	60% of Allowed Benefit
Urgent Care center	No Deductible required 100% of Allowed Benefit after \$30 Copay	60% of Allowed Benefit
Dental services related to accidental injury or trauma	80% of Allowed Benefit	60% of Allowed Benefit

*Copay waived if admitted.

**Copay applies to the office exam only.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
General anesthesia and associated hospital or ambulatory surgical facility services for dental care	Limitations An approved Plan of Treatment may be required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	Limitations An approved Plan of Treatment is required for Home Health Care. Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS) provided under the Total Care and Cost Improvement Program. Hospital/home health agency: Twenty (20) Home Health Care Visits per Benefit Period.	
	80% of Allowed Benefit	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care	Limitations An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and/or family. Benefits for Hospice care services are limited to a maximum two-hundred and forty (240) days per Benefit Period. Benefits for bereavement counseling are limited to three (3) visits within one year of the family member's death.	
	80% of Allowed Benefit	Paid the same as in-network

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services		
Infertility services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient hospital or health care facility	Limitations Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
Facility	80% of Allowed Benefit	50% of Allowed Benefit
Inpatient practitioner	80% of Allowed Benefit	60% of Allowed Benefit
Skilled Nursing Facility	Limitations Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to sixty (60) days per Benefit Period combined with Inpatient rehabilitation. Admission must be within fourteen (14) days of a hospital confinement of at least three (3) days.	
	No Deductible required 80% of Allowed Benefit	No Deductible required 60% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	80% of Allowed Benefit	50% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Cleft lip or cleft palate, or both		
Oral surgery		
Facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Otological, audiological and speech/language treatment		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	No prior authorization required for maternity admissions.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mastectomy-Related Services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	80% of Allowed Benefit	60% of Allowed Benefit
Hair prosthesis (Cancer diagnosis only)	Limitations Benefits for hair prosthesis are limited to \$500 per Benefit Period.	
	80% of Allowed Benefit	70% of Allowed Benefit
Medical foods and nutritional substances	80% of Allowed Benefit	60% of Allowed Benefit
Medical Supplies		
Orthotic Devices, Prosthetic Devices		
Treatment of temporomandibular joint dysfunction	Limitations Benefits for the treatment of temporomandibular joint dysfunction are limited to \$600 lifetime maximum.	
	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mental health and Substance Use Disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient Health Care Provider Services	Limitations Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services	Benefits for outpatient care are available, including: <ul style="list-style-type: none"> • Partial hospitalization; • methadone maintenance treatment; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy. 	
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$30 Copay	60% of Allowed Benefit
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests and X-Rays		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office and/or independent laboratory	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit
Other diagnostic services		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	Limitations Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services.	
Organ and tissue transplants and Related Services performed and/or provided at a Blue Distinction Center (BDC)	Organ/tissue transplant and services provided by a BDC for the first ninety (90) days from the date of transplant: No Deductible required 100% of Allowed Benefit Services provided by a BDC ninety (90) days after date of transplant: Benefit are available to the same extent as benefits provided for other illnesses.	No benefit
Organ and tissue transplants and transplant-related services provided by other providers (Non-Blue Distinction Centers)		
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel and lodging		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Services provided in an hospital emergency room for non-Emergency Medical Conditions and illness visits		
Hospital emergency room/department facility services	50% of Allowed Benefit after \$100 Copay* *Copay waived if Member is admitted.	
Outpatient professional practitioner services provided in a hospital emergency room/department	50% of Allowed Benefit	
Services provided in other places of service for non-Emergency Medical Conditions and illness visits		
Outpatient hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office/home	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit
Medical care and consultations at Perdue HealthWorks/Perdue Wellness Center		
Non-routine/non-preventive services	<u>Subscriber:</u> No Deductible required 100% of Allowed Benefit <u>Dependent:</u> No Deductible required 100% of Allowed Benefit after \$15 Copay	Not applicable
Preventive and wellness services and screenings	No Deductible required 100% of Allowed Benefit	Not applicable
Urgent Care center	Benefits are available to the same extent as benefits provided for Emergency Services provided in an Urgent Care facility.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Ambulatory surgical facility services	80% of Allowed Benefit	60% of Allowed Benefit
Anesthesia	80% of Allowed Benefit	Paid the same as in-network
Surgical assistant		
Female elective sterilization	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Administration of injectable Prescription Drugs	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)		
Allergenic extracts (sera)		
Allergy testing		
Chemotherapy		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Home Infusion Therapy	80% of Allowed Benefit	60% of Allowed Benefit
Inhalation therapy		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Radiation therapy		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Renal dialysis		
Hospital	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Spinal manipulation	Limitations Spinal manipulation is limited to twenty-five (25) days per Benefit Period.	
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	Limitations An approved Plan of Treatment is required. No inpatient Private Duty Nursing benefits are available. Outpatient private duty nursing is limited to twenty (20) days per Benefit Period.	
Facility/agency	80% of Allowed Benefit	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drugs	Limitations Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: <ul style="list-style-type: none"> allergenic extracts (allergy sera) injectable Prescription Drug contraceptives and contraceptive devices 	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy		
All outpatient places of service	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Inpatient Rehabilitative Services	Limitations Hospital Pre-Certification and Review is required.	
	Inpatient facility rehabilitation is limited to sixty (60) days per Benefit Period, combined with Skilled Nursing Facility. Benefits are available to the same extent as inpatient benefits provided for other illnesses.	
Outpatient Rehabilitative Services		
Occupational Therapy	Limitations Occupational Therapy benefits are limited to twenty-five (25) days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Physical Therapy	Limitations Physical Therapy benefits are limited twenty-five (25) days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Speech Therapy	Limitations Speech Therapy benefits are limited to twenty-five (25) days per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit
Cardiac Rehabilitation		
Hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Outpatient Rehabilitative Services		
Habilitative Services	Limitations Habilitative Services for autism or an autism spectrum disorder does not include Applied Behavioral Analysis services.	
	Outpatient rehabilitative services visit limits, if any, apply to Habilitative Services Covered Services.	
	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Pulmonary Rehabilitation		
Hospital/facility	80% of Allowed Benefit	60% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	60% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Wellness services provided by the Group's Designated Wellness Services Provider	No Deductible required 100% of Allowed Benefit*	

* The Allowed Benefit is the Designated Wellness Services Provider's actual charge.

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

**TOTAL CARE AND COST IMPROVEMENT, PATIENT-CENTERED MEDICAL HOME,
ENHANCED MONITORING PROGRAM, EXPERT CONSULTATION PROGRAM,
SUBSTANCE USE DISORDER PROGRAM, HEALTH PROMOTION AND WELLNESS
PROGRAM, AND DISEASE MANAGEMENT ADDENDUM**

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SECTION 1	DEFINITIONS	
SECTION 2	DESCRIPTION OF COVERED SERVICES	
	TCCI Covered Services and Cost Sharing Waiver	This section describes certain TCCI program components, services available to eligible members, and the cost-share waiver requirements for such components.
	PCMH Covered Services	This section describes the PCMH program.
	Enhanced Monitoring Program	These sections describe the TCCI program components available without an active plan of care.
	Expert Consultation Program	
	Substance Use Disorder Program	
	Health Promotion and Wellness Covered Services	This section describes the prevention and wellness services for members to help them avoid getting sick.
	Disease Management Covered Services	This section describes the disease management services for members to address and manage diseases they may have.
SECTION 3	SCHEDULE OF BENEFITS	

This Addendum is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. The effective date of coverage and termination date of coverage under this Addendum are the same as the effective date and termination date stated in the Group's Administrative Services Agreement for the benefits described herein.

The provisions of this Addendum do not apply to Members for whom Medicare is the primary carrier.

SECTION 1. DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage, for purposes of this Addendum, the underlined terms, below, when capitalized, have the following meaning:

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

Care Coordination Team, for purposes of the Patient-Centered Medical Home Program, means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, for purposes of the Patient-Centered Medical Home Program, means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses and includes case management through the Substance Use and Behavioral Health Program.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: Patient-Centered Medical Home Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Use and Behavioral Health Program, or other community-based programs outlined in this section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Enhanced Monitoring Program (EMP) means the CareFirst program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Expert Consultation Program (ECP) means the CareFirst Program for Members with a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

Health Promotion and Wellness Program means a coordinated program designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Health Care Provider, for purposes of the Patient-Centered Medical Home Program, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this section.

Primary Care Physician (PCP), for purposes of this Addendum, means health care practitioners in the following disciplines:

1. General practice medicine;
2. General internal medicine;
3. Family practice medicine;
4. Pediatric medicine; or
5. Geriatric medicine.

Qualifying Individual, for purposes of the Patient-Centered Medical Home Program, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Qualified Member means a Member who:

1. Is accepted by CareFirst into one or more of the TCCI Programs described in this section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.
2. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.
3. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.
4. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

Specialist, for purposes of this Addendum, means a licensed health care provider who is certified or trained in a specified field of medicine.

Substance Use Disorder means:

1. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or
2. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

Weight Loss Services means CareFirst approved services available to clinically obese Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion and Wellness Program.

Wellness Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Wellness Program.

SECTION 2. DESCRIPTION OF COVERED SERVICES

Benefits are available for:

A. TCCI Covered Services and Cost Sharing Waiver

1. Qualified Members are eligible for a waiver of certain cost sharing responsibility for benefits provided under this section when:
 - a. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or
 - b. At CareFirst's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in a CCM Program or a CCC Program.
2. Qualified Members participating in a CCM Program or a CCC Program as set forth in paragraph A.1.a., are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:
 - a. Assessment of Qualified Member/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;
 - b. Education of Qualified Member/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;
 - c. Assistance in navigating and coordinating health care services and understanding benefits;
 - d. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;
 - e. Assistance in arranging consultation(s) with Specialists;
 - f. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;
 - g. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.
 - h. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.
 - i. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

3. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under paragraph A.1.a., or, pursuant to CareFirst initiation under paragraph A.1.b., are eligible for benefits under following TCCI Program elements:
 - a. Comprehensive Medication Review (CMR). Benefits will be provided for a Pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.
 - b. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.
 - c. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.
 - d. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any Home Health Care visit limits stated in the Schedule of Benefits.
 - e. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.
 - f. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.
 - g. Substance Use and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and Substance Use Disorder services, including behavioral health treatment benefits.
4. Qualified Member Cost Sharing Responsibilities.
 - a. Any applicable cost-sharing responsibilities under this section (TCCI Covered Services and Cost Sharing Waiver) will be waived for (i) TCCI Program services provided by a Designated Provider, and (ii) in-network services provided to Qualified Members in an active plan of care.
 - b. Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits (ii) services provided in an inpatient institution or facility, or (iii) any services provided in a hospital.
 - c. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:
 - 1) If the Qualified Member has funded his/her HSA account during the calendar year, then the Qualified Member will be responsible for any associated costs for services under this section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

- 2) If the Qualified Member has not funded his/her HSA account during the calendar year, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in paragraph A.4.a.

5. Termination

- a. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this section will be terminated under the following circumstances:
 - 1) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner.
 - 2) When confirmed by the Qualified Member's treating physician or nurse practitioner if the TCCI Program(s) benefits are provided to Qualified Members not in an active plan of care.
 - 3) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.
 - 4) The Qualified Member's coverage under the Evidence of Coverage is terminated.
- b. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under paragraph A.5.a.3), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this section.
- c. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the effective date of the termination of the waiver.

B. PCMH Covered Services

Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.
2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.
3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;
4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

C. Enhanced Monitoring Program

Benefits for medical equipment and monitoring services will be provided to a Member, without an active plan of care, who qualifies under the EMP as determined by CareFirst.

D. Expert Consultation Program

Benefits for review of a Member's medical records by a team of specialists will be provided to a Member, without an active plan of care, who qualifies under the ECP as determined by CareFirst. The review of the Member's medical records will be done in accordance with the ECP.

E. Substance Use Disorder Program

Benefits will be provided for outpatient treatment of Substance Use Disorder, without an active plan of care, if:

1. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst;
2. The Member receives treatment from a recognized treatment center of excellence, as determined by CareFirst; and
3. Treatment is rendered through an intensive outpatient program (IOP) or an outpatient program at a recognized center of excellence as determined by CareFirst.

F. Health Promotion and Wellness Covered Services

1. Health Assessments are available for all adult Members.
2. Benefits are available for Biometric Screening of Members, as defined above.
3. Lifestyle Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.
 - b. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).

4. Other Wellness Program benefits are available, which may include tobacco-cessation, well-being challenges, and financial well-being improvement programs.
5. Weight Loss Services are available to clinically obese Members, as follows:
 - a. A clinically obese Member is a Member whose Body Measurement Index (BMI) score is greater than thirty (30).
 - b. A dedicated, CareFirst approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.
 - c. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

G. Disease Management Covered Services

1. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.
2. Disease Management Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.
 - b. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

SECTION 3. SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies, or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment, as stated below.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Total Care and Cost Improvement Program	Limitations Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for TCCI Program or Patient-Centered Medical Home Program.	
TCCI program services provided pursuant to a plan of care	No Deductible required 100% of Allowed Benefit	No benefit
TCCI Program elements		
TCCI program services provided without a plan of care: Enhanced Monitoring Program, Expert Consultation Program, Substance Use Disorder Program	No Deductible required 100% of Allowed Benefit	No benefit
Patient-Centered Medical Home Program	Limitations Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst approved Health Care Provider who has elected to participate in the CareFirst Patient-Centered Medical Home Program.	
	No Deductible required 100% of Allowed Benefit	No benefit
Health Promotion and Wellness	Limitations Benefits for Weight Loss Services are only available to Members with a BMI score greater than thirty (30).	
Biometric Screening services	No Deductible required 100% of Allowed Benefit	No benefit
Wellness Coaching services		
Other Wellness Program services		
Weight Loss Programs		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Disease Management		
Disease Management services	No Deductible required 100% of Allowed Benefit	No benefit
Disease Management Coaching services	No Deductible required 100% of Allowed Benefit	No benefit

This Addendum is issued to be attached to the Evidence of Coverage.

CLAIMS PROCEDURES

Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group Health Plan has deemed itself subject to ERISA.

- A. DEFINITIONS**
- B. CLAIMS PROCEDURES**
- C. CLAIMS PROCEDURES COMPLIANCE**
- D. CLAIM FOR BENEFITS**
- E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)**
- F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**
- G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS**
- H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL**
- I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**
- J. NOTICE**
- K. EXTERNAL REVIEW PROCESS**

A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,
2. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Claimant's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an InDependent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

Group Health Plan means an employee welfare benefit Plan within the meaning of section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of section 733(a) of the Act.

Health Care Professional means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

InDependent Review Organization (or IRO) means an entity that conducts inDependent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the claims administrator under this Group Contract.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Claimant's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeal of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Claimants.

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Rescissions are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.

C. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Claimant or authorized representative.

The above shall apply only in the case of a failure that:

- a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and
- b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA or under State law, as applicable.

D. CLAIM FOR BENEFITS

A Claim for Benefits is a request for a Plan benefit or benefits made by a Claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

1. In general. Except as provided in paragraph E.2, if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.
2. The Claimant shall be notified of the determination in accordance with the following, as appropriate.
 - a. Expedited Notification of benefit determinations involving urgent care. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
 - 1) Receipt of the specified information, or
 - 2) The end of the period afforded the Claimant to provide the specified additional information.

- b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
 - 1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
 - 2) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and Appeal shall be governed by paragraphs H.2.a, H.2.b, or H.2.c, herein as appropriate.
 - 3) Continued coverage will be provided pending the outcome of an Appeal.
- c. Other claims. In the case of a claim that is not an urgent care claim or a concurrent care decision the Claimant shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.
 - 1) Pre-Service Claims. In the case of a Pre-Service Claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein.

- 2) Post-Service Claims. In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.
 - d. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.c above due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
3. Deemed exhaustion of internal claims and Appeals processes. If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:
 - a. The specific reason or reasons for the adverse determination;
 - b. Reference to the specific Plan provisions on which the determination is based;
 - c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
 - d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the Act following an Adverse Benefit Determination on review;
 - e. In the case of an Adverse Benefit Determination:
 - 1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
 - 2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
 - f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.
2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in paragraph E.2.a herein, provided that a written or electronic Notification in accordance with paragraph F.1 of this section is furnished to the Claimant not later than three (3) days after the oral Notification.

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

1. To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within 180 days of the Adverse Benefit Determination.
2.
 - a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
 - b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;
 - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;
 - b. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
 - c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - d. Health Care Professionals engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and
 - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and
 - b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.
5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided below and in paragraph H.2, a Claimant shall be Notified in accordance with paragraph I. herein of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.
2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.
 - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.
 - b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

- c. Post-service claims. In the case of a Post-Service Claim, except as provided below, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
- 3. Calculating time periods. For purposes of paragraph H. herein, the period of time within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph I.1 herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
- 4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs I.3, I.4, and I.5 herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

- 1. The specific reason or reasons for the adverse determination;
- 2. Reference to the specific Plan provisions on which the benefit determination is based;
- 3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;
- 4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and
- 5.
 - a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
 - b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and or your State insurance regulatory agency.

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan's Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:
 - a. The Plan or the Plan's Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
 - b. The Plan or the Plan's Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan's Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.
 - c. The Plan or the Plan's Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.
 - d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.
 - e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.
2. Form and manner of Notice.
 - a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.
 - b. Requirements
 - 1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;
 - 2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and

- 3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.
- c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.
2. If a Claimant is in need of assistance, they may contact the appropriate agency as follows:

Maryland Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(877) 261-8807
<http://www.oag.state.md.us/Consumer/HEAU.htm>
heau@oag.state.md.us

Additionally, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

3. Scope
 - a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.
 - b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:
 - 1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and

- 2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).
4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

- a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:
 - 1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - 2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);
 - 3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and
 - 4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

- c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

- 1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- 2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- 3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.
- 4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.

- 5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
- (a) The Claimant's medical records;
 - (b) The attending health care professional's recommendation;
 - (c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;
 - (d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- 6) The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.
- 7) The assigned IRO's decision Notice will contain:
- (a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;
 - (f) A statement that judicial review may be available to the Claimant; and
 - (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - 8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
 - d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
5. Expedited External Review for self-insured Group Health Plans
- a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:
 - 1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;
 - 2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
 - b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.

- c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.

- d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.

6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

APPENDIX A

The Prescription Drug Program

Enrollment in the Plan automatically includes coverage under the Prescription Drug Program. This program is administered separately from your medical benefits under the Plan by Express Scripts.

How the Prescription Drug Program Works

The Prescription Drug Program offers you the following two ways to fill prescriptions:

- At a local participating pharmacy;
- By home delivery (mail order), phone or online.

After two fills at a retail pharmacy for drugs you use on an ongoing basis, often referred to as maintenance drugs, you will be required to move your prescription to either the Express Scripts home delivery pharmacy or to a CVS or Walgreens pharmacy and fill the prescription as a 90-day prescription. After the courtesy fills are exhausted, you must pay the full cost of the prescription if you have not transitioned your maintenance medications to a Walgreens, CVS or the Express Scripts Pharmacy for a 90-day supply.

Regardless of your choice of pharmacy, you should present the ID card you received at enrollment along with your prescription. This may allow the pharmacy to help you file a claim for benefits.

Your cost varies depending on the type of drug and how you choose to fill your prescriptions.

Retail – Participating Pharmacy

If you fill your prescription at a retail pharmacy that is an Express Scripts participating pharmacy, the pharmacist will charge you the coinsurance amount for your prescription. However, your coinsurance will never be below or above specified amounts. (See "Amount of Coinsurance" below for details.)

The amount you pay at a retail participating pharmacy for up to a 30-day supply is:

- For generic non-specialty drugs—20%, subject to an \$8 minimum and a \$16 maximum;
- For generic specialty drugs—20%, subject to a \$16 minimum and a \$32 maximum;
- For preferred brand non-specialty drugs—20%, subject to a \$30 minimum and a \$60 maximum; and
- For preferred brand specialty drugs—30%, subject to a \$50 minimum and a \$100 maximum.

Most specialty medications are required to be filled through Express Scripts Accredo specialty pharmacy. Only specialty medications that are considered emergency or stat specialty medications can be filled for the first fill at a retail pharmacy. After that, you must use the Plan's Express Scripts Accredo specialty pharmacy service.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

Medications that are filled for 90-days through a Walgreens or CVS pharmacy will follow the home delivery plan design that is outlined below.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

After two fills at a retail pharmacy for drugs you use on an ongoing basis, often referred to as maintenance drugs, you will be required to move your prescription to either the Express Scripts home delivery pharmacy or to a CVS or Walgreens pharmacy and fill the prescription as a 90-day prescription. After the courtesy fills are exhausted, you must pay the full cost of the prescription if you have not transitioned your maintenance medications to a Walgreens, CVS or the Express Scripts Pharmacy for a 90-day supply.

To find a participating retail pharmacy near you:

- Call Express Scripts toll-free at 1-800-211-8497;
- Access Express Scripts online at www.express-scripts.com; or
- Download the Express Scripts Mobile App.

Ask your local pharmacy if it is an Express Scripts participating pharmacy.

Retail – Nonparticipating Pharmacy

You must pay the full cost for your prescription when you use a nonparticipating pharmacy.

Express Scripts Home Delivery (Mail Order)

The Express Scripts mail service is a great way to fill prescriptions for medication you take on a long term or ongoing basis. You may receive up to a 90-day supply for one copayment. (See "Amount of Copayment or Coinsurance" below for details.)

Home delivery (mail order) may be your best option for prescription drugs that you take on a regular *basis for conditions such as asthma, high blood pressure, and high cholesterol*. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and sent to you in a plain, weather-resistant pouch for privacy and protection.

You may get up to a 90-day supply of your medications—which may mean fewer refills and fewer visits to your pharmacy, as well as lower costs. Once you begin using the home delivery, you can order refills online, by phone, through the mobile app or by mail.

You can choose between these easy options:

- Call Express Scripts at the toll-free number on the back of your member ID card and let Express Scripts do all the work. For most medications, Express Scripts will be able to contact your doctor for you and arrange for your first mail-order supply.

- Visit **www.express-scripts.com/StartHD**. After logging in, select “Transfer your retail prescriptions” to get started. The Express Scripts Pharmacy will contact your doctor for you to obtain a 90-day prescription.
- Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate). Then, ask your doctor to electronically send the prescription to the Express Scripts Pharmacy.

To transfer any remaining maintenance medication refills from a retail pharmacy to home delivery, log in or register at **Express-Scripts.com** and look for “Transfer to Home Delivery” on the home page. Select the medications you’d like to transfer, click “Add to Cart” and checkout. Express Scripts does the rest.

Orders are usually processed 48 hours from when Express Scripts gets them. Your medicine should be delivered in about 8 days (10-14 days if it’s a new prescription). If Express Scripts needs to contact your doctor for information, delivery may take longer. You can check your order status by going online anytime. Your prescription drug will be mailed to your home at no charge for standard U.S. Postal Service delivery. You may request overnight delivery for an additional charge. You may also indicate if you want your medicine in a child-resistant or non-child-resistant bottle.

A pharmacist is available 24 hours a day to answer questions about your medicines.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy coinsurance will apply.

Your copayment for each prescription filled through home delivery is:

- For generic non-specialty drugs—20%, subject to an \$16 minimum and a \$32 maximum;
- For generic specialty drugs—20%, subject to a \$16 minimum and a \$32 maximum;
- For preferred brand non-specialty drugs—30%, subject to a \$50 minimum and a \$100 maximum; and
- For preferred brand specialty drugs—30%, subject to a \$50 minimum and a \$100 maximum.

Home delivery of a 90-day supply of insulin, syringes, and diabetic supplies, will be covered at the same rate as a retail 30-day supply.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Amount of Coinsurance

The amount of your copayment or coinsurance depends on where your prescription is filled, whether it is filled with a generic or brand drug, and whether it is for a specialty or non-specialty drug.

Type of Drug	In-Network Retail	Walgreens/CVS/ESI Mail Order	Out-of-Network
Generic Non-Specialty	20% coinsurance, subject to \$8 minimum and \$16 maximum (30-day supply)	20% coinsurance, subject to \$16 minimum and \$32 maximum (90-day supply)	not covered
Generic Specialty	20% coinsurance, subject to \$16 minimum and \$32 maximum (30-day supply) (1 fill only)	20% coinsurance, subject to \$16 minimum and \$32 maximum (30-day supply)	not covered
Preferred Brand Non-Specialty	20% coinsurance, subject to \$30 minimum and \$60 maximum (30-day supply)	30% coinsurance, subject to \$50 minimum and \$100 maximum (90-day supply)	not covered
Preferred Brand Specialty	30% coinsurance, subject to \$50 minimum and \$100 maximum (30-day supply) (1 fill only)	20% coinsurance, subject to \$50 minimum and \$100 maximum (30-day supply)	not covered
Insulin, Syringes, and Diabetic Supplies	Retail coinsurance and limits apply (30-day supply)	Retail coinsurance and limits apply (30-day supply)	not covered

Your medical and prescription drug claims are combined when determining whether you have met the In-Network Out-of-Pocket Maximum. Once the In-Network Out-of-Pocket maximum amount is met, the Plan will pay 100% of your allowable medical and prescription drug costs.

In-Network Out-of-Pocket Maximum:

- \$6,000 Single (Employee only)
- \$12,000 Family (Employee+Spouse, Employee+Child, Family)

How Prescription Drugs Are Classified

A **generic drug** is a medication chemically equivalent to a brand name drug on which the patent has expired. Generic versions of brand name drugs contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs. See the section "Generics Preferred" for details about how the Plan pays benefits for generic drugs.

A **preferred brand-name drug** is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. A preferred brand drug is a drug that is included on the Plan's drug formulary list as a prescription drug product preferred by the Prescription Drug Program for dispensing. Preferred brand name drugs do not have a generic equivalent. These medicines have been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and have been selected by Express Scripts to be included in the formulary based on their proven clinical and cost effectiveness.

Non-preferred brand-name drugs are not included on the Plan's drug formulary list, and generally they are not covered by the Prescription Drug Program. These drugs usually have an alternative therapeutically-equivalent drug available. In the rare event that your medical condition requires a non-preferred drug, and if you have tried and failed with two similar drugs on the formulary list, your doctor may contact Express Scripts to ask to have a non-preferred drug authorized for you. If your request is approved, benefits for the non-preferred drug will be the same as they would be for the preferred brand. The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs.

There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Drugs Requiring Prior Authorization

Some drugs require prior authorization. This means that Express Scripts will need to make sure these prescriptions meet the Plan's conditions for coverage. (You can contact Express Scripts for a current list of drugs that require prior authorization.) If a drug you take requires prior authorization, your physician will need to contact Express Scripts for a clinical review. If your prescription is authorized, you will pay your copay. If the prescription is not approved for coverage, and you and your physician decide that you should still take the prescribed drug that was not authorized, you will pay the full cost of the medication.

To determine if your medication requires prior authorization, **your physician** (not you) should call the Express Scripts' prior authorization line at 1-800-753-2851. The best way to avoid inconvenience is to have your physician contact the Express Scripts prior authorization department either electronically or by calling the prior authorization line before you go to the pharmacy or send for your prescription by mail. The prior authorization line is not for patient use. You cannot obtain prior authorization by calling this line yourself.

Dispensing Limits and Other Limits

To promote safety and appropriate and cost-effective use of prescription drugs, the Prescription Drug Program includes a "drug quantity management" feature. For certain prescription drugs, it places a limit on the quantity that can be dispensed at one time. Quantity dispensing limits are based on:

- The manufacturer's recommended dosage and duration of therapy;
- Common usage for episodic or intermittent treatment;
- FDA-approved recommendations and/or clinical studies; and
- Guidelines of the Plan.

In addition to the above limits, the Prescription Drug Program limits the number of days for which a prescription can be filled. For each prescription filled for a non-specialty drug, you can obtain a supply of up to 90 days. For each prescription filled for a specialty drug, you can obtain a supply of up to 30 days.

The Prescription Drug Program provides benefits for fertility drugs, **up to a lifetime maximum benefit of \$10,000**. Benefits are not otherwise available for the treatment of Infertility.

Step Therapy Program

"Step therapy" manages appropriate use of first-line, clinically effective, lower-cost drugs before using a more expensive second-line drug. Step therapy requires patients to receive a trial of one or more first-line drugs before prescriptions are covered for second-line drugs when medically appropriate.

To promote the use of cost-effective first-line therapy, the Prescription Drug Program applies step therapy for certain drug categories, including but not limited to the following:

- Arthritis and pain medicines (COX-2s) such as Celebrex;
- Blood pressure or heart medicines (angiotensin receptor antagonists) such as Diovan and Benicar;
- Asthma, allergic rhinitis, and chronic bronchitis medicines such as Aerospans;
- High cholesterol medicines (HMGs) such as Crestor and Vytorin; and

A physician can override the step therapy program **when appropriate for medical reasons** by submitting a prior authorization request to Express Scripts by calling 1-800-753-2851.

Management of Pain Medications called Opioids:

Express Scripts proactively educates patients new to pain medications called opioids and related therapies via member-friendly outreach outlining risks and safety tips for taking their prescription, and proper disposal of unused medications. To maximize patient safety by minimizing early opioid and related therapies exposure, Express Scripts requires prior authorization and limits on the quantity of opioid medications that can be dispensed at one time. These requirements do not apply if a member has a history of cancer or palliative care.

- **Days' Supply Limit of a First Fill of a Short Acting Opioid:** To prevent excess opioid medications, a days' supply limit is placed on the first fill of a short acting opioid for new opioid users.

- **Prior Authorization on all Long Acting Opioids:** To ensure that patients are appropriately started on long-acting opioids, Express Scripts will implement a Prior Authorization on all long-acting opioids if the member has not had a prior fill for an opioid.
- **Morphine Equivalent Dose (MED) based quantity limit:** As not all opioids are the same, this quantity limit manages the potential over-utilization of opioid medications by tracking the Morphine Equivalent Dose (MED) for each opioid dispensed. This cumulative quantity level limit sums from each active prescription the result of morphine equivalent dose calculations – a conversion factor of the pain relief value of an opioid medication to the comparable pain relief provided by morphine - and compares it to a pre-defined threshold which requires additional review and prior authorization, if exceeded.
- **Quantity Limit on Fentanyl Patches:** Fentanyl products are generally only approved for treatment of breakthrough cancer pain and are considered long-acting opioids. To ensure continued patient safety and alignment with FDA recommendations, Express Scripts has placed quantity limits on the number of fentanyl patches that can be dispensed at one time.
- **Prior Authorization on Transmucosal Immediate Release Fentanyl (TIRF) Products:** TIRF products are approved only for treatment of breakthrough cancer pain. To support FDA guidelines, Express Scripts has implemented a prior authorization requirement on these products to ensure an additional prescriber evaluation is completed prior to dispensing.

Express Scripts Specialty Pharmacy

Accredo is Express Scripts' full-service specialty pharmacy. It serves a wide range of patients, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and post-transplant needs.

Most specialty medications are required to be filled through Express Scripts Accredo specialty pharmacy. Only specialty medications that are considered emergency or stat specialty medications can be filled for the first fill at a retail pharmacy. After that, you must use the Plan's Express Scripts Accredo specialty pharmacy service.

Accredo offers a complete range of services and specialty drugs, many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medicine.

To begin receiving your specialty drugs through Accredo, call them toll-free at 1-800-803-2523. Accredo services include:

- Patient counseling — convenient access to pharmacists and nurses who are specialty medicine experts;
- Patient education — education material;
- Convenient delivery — coordinated delivery to your home, your doctor's office, or other approved location;
- Refill reminders; and
- Language assistance — interpreting services for non-English-speaking patients.

Prescription Drug Program Exclusions

- The following are not covered under the Prescription Drug Program:
- Drugs and medicines that ordinarily can be obtained without a prescription (i.e. over-the-counter medications);
- Erectile dysfunction drugs (e.g., Viagra);
- Anabolic steroids (e.g., Winstrol, Anadrol-50, Oxandrin, Deca-Durabolin);
- Appetite suppressants and other weight loss products;
- Durable medical equipment (except for nebulizer/supplies, breathing devices-peak meters and breathing supplies) ;
- Injectable serums, vaccines or allergens;
- Legend hair growth products (e.g., Propecia);
- Legend hair removal products (e.g., Vaniqa);
- Legend vitamins (except prenatal vitamins, b-12 injection, vitamins with fluoride);
- Prescriptions that exceed the 90-day limit;
- All proton-pump inhibitors (PPI) products (e.g., Prilosec, Nexium, Prevacid) that treat conditions such as heartburn;
- Not more than 1 replacement prescription for vacation override or lost or stolen prescription; and
- Any drug or chemical not approved by the Food and Drug Administration in the dosage prescribed, for the reason prescribed, or in the form prescribed. This includes, but is not limited to, non-FDA approved compounded drugs.

Note that if you participate in the HealthCare Flexible Spending Account, the portion you pay for over-the-counter medications may be eligible for reimbursement through your health care FSA if you submit a written prescription from your doctor for the medication.

For certain other prescription drug exclusions, please consult the section of this Booklet entitled "Expenses Not Covered."

Filing a Prescription Drug Claim

You do not need to file a claim if you use a participating pharmacy. You only need to complete a special order envelope when you use home delivery. On a refill, it is even easier; you can just call or go online and provide your credit card number.

If you use a nonparticipating pharmacy, you need to pay the full cost for the prescription and file a claim for reimbursement.

Information When You Need It at www.express-scripts.com

Go online to www.express-scripts.com for 24-hour access to information regarding the Prescription Drug Program. Use this website to:

- Find out about your copayment amounts;
- Verify coverage for eligible dependents;
- View or print a list of drugs included in the Plan's formulary;
- Locate participating retail pharmacies near you;
- Review your 12-month prescription history;
- Order refills; and
- Check the status of your mail order prescription.

Register now to access www.express-scripts.com. Once you are registered, you will have the information you need

The Express Scripts Mobile App

The Express Scripts mobile application (app) helps members make better decisions for healthier outcomes – anytime, anywhere. The app has earned a consistent 4.5 star rating for all versions beginning in 2015.

The app is compatible with most iPhone®, iPad®, Android™, Windows Phone®, Amazon and BlackBerry® mobile devices. To download the Express Scripts mobile app, members should search for “**Express Scripts**” in their mobile device’s app store and download it for free.

Note: Features available on the mobile app are based on the member’s plan design and the Perdue’s profile set-up.

Members who are not already registered via express-scripts.com will need to create a username and password by registering on the app before they can have a fully personalized mobile experience. The same username and password can be used to access express-scripts.com.

Members who have **Apple’s touch ID authentication** on their iPhone or iPad devices can enable it to login to their Express Scripts account on the mobile app, if desired.

Members can navigate to the mobile website from their internet browser on their mobile device. The mobile website has the same features and functionality as the Express Scripts mobile app.

Perdue Farms Inc.

BluePreferred Option- ADV 10

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance make the Group Contract's terms and provisions binding on CareFirst and the Group.

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part. Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Individuals enrolled in the Plan are also covered by the Prescription Drug Program described in Appendix A. Appendix A is not part of the Evidence of Coverage or the Group Contract and is not administered by CareFirst—it is administered by Express Scripts. It is being provided together with this Evidence of Coverage solely for the convenience of the participants. As described more fully in the Evidence of Coverage, both covered medical expenses and covered prescription drug expenses count toward the Plan's deductibles and out-of-pocket maximums.

Group Name: **Perdue Farms Inc.**

Account
Number(s): **67088**

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. **Preferred Health Care Providers:** For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.
2. **Non-Preferred Health Care Providers:**
 - a. **Non-Preferred health care practitioner:** For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or CareFirst's established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.
 - b. **Non-Preferred hospital or health care facility:** For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or CareFirst's established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.
 - c. **Non-Preferred Emergency Services Health Care Provider:** CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:
 - 1) The Allowed Benefit stated in paragraphs 2.a., or 2.b.
 - 2) The amount negotiated with Preferred Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Preferred Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

- 3) The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Preferred Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.
- 4) The amount that would be paid under Medicare (part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

Adverse Decision means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: **January 1st** through **December 31st**.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process and enhance the psychosocial and vocational status of Eligible Members.

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member whereby CareFirst and the Member share in the payment for Covered Services.

Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that has contracted with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated in the Inter-Plan Ancillary Services section.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hooyer/stair lifts, ramps, shower/bath bench, items available without a prescription).

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one Copay.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

Deductible means the dollar amount of Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him/herself.

Dependent means a Member other than the Subscriber, meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained the Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment; or
6. Satisfaction of any combination of the above factors.

Designated Wellness Services Provider means a third-party service provider contracted by Group to provide specific wellness services to Members. For purposes of this Evidence of Coverage, the Group's Designated Wellness Services Provider is a Non-Preferred Provider. Services provided by the Group's Designated Wellness Services Provider are as defined by the Group. For description of such services please contact the Group directly.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage means this agreement, which includes the acceptance, riders and amendments, if any, between the Group and CareFirst (also referred to as the Group Contract).

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA means the U.S. Food and Drug Administration.

Group means the Subscriber's employer/Plan Sponsor or other organization to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the Group Contract includes any riders and/or amendments attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Habilitative Services means health care services and devices, including, but not limited to, Occupational Therapy, Physical Therapy, and Speech Therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

Infusion Therapy means treatment that places therapeutic agents into the vein, including intravenous feeding.

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

Limiting Age means the maximum age to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Director means a board-certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. Not primarily for the convenience of a patient or Health Care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

Member means an individual who meets all applicable eligibility requirements, is enrolled either as a Subscriber or Dependent, and for whom payment has been received by CareFirst.

Non-Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that does not contract with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated in the Inter-Plan Ancillary Services section.

Non-Preferred Health Care Provider means any Health Care Provider that is not a Preferred Provider.

Occupational Therapy means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

Paid Claims means the amount paid by CareFirst for Covered Services. Inter-Plan Arrangements Fees and Compensation are also included in Paid Claims. Other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator may also be included in Paid Claims.

Physical Therapy means the short-term treatment described below that can be expected to result in an improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan of Treatment means the plan written and given to CareFirst by the attending Health Care Provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The contracted Preferred Provider has the obligation of referring Members within the network. Preferred Provider relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.

A listing of Preferred Providers may be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any Health Care Provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means:

1. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription."
2. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
3. Prescription Drugs do not include:
 - a. Compounded bulk powders that contain ingredients that:
 - 1) Do not have FDA approval for the route of administration being compounded, or
 - 2) Have no clinical evidence demonstrating safety and efficacy, or
 - 3) Do not require a prescription to be dispensed.
 - b. Compounded drugs that are available as a similar commercially available Prescription Drug unless:
 - 1) There is no commercially available bio-equivalent Prescription Drug; or
 - 2) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Private Duty Nursing means Skilled Nursing Care that is not rendered in a hospital/Skilled Nursing Facility.

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Service Area means CareFirst's Service Area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members.

Skilled Nursing Care, depending on the place of service or benefit, means:

1. Inpatient hospital/facility or Skilled Nursing Facility:
 - a. Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
2. Skilled Nursing Care provided in the home:
 - a. Medically Necessary skilled care services performed by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).
 - b. Skilled Nursing Care home visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if the visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
 - c. Services of a home health aide, medical social worker or registered dietician performed under the supervision of a licensed professional (RN or LPN) nurse.
 - d. Skilled Nursing Care services in a Home Health Care setting must be based on a Plan of Treatment submitted by a Health Care Provider.
3. Outpatient Private Duty Nursing:
 - a. Medically Necessary skilled care services performed by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).
 - b. Skilled Nursing Care must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if the visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
 - c. Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.

Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition, absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist means a physician who is certified or trained in a specified field of medicine.

Specialty Drug means Prescription Drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns – requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy means the treatment of communication impairment and swallowing disorders. Speech Therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family except for Benefits for Members Entitled to Medicare (Medicare Complementary) in which case Type of Coverage means Individual coverage. Additional categories of coverage do not apply to Benefits for Members Entitled to Medicare. Each Medicare-eligible person, including a Medicare-eligible Dependent, will be enrolled in an Individual Type of Coverage category under the Group Contract.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

Waiting Period means the period of time that must pass before an employee or Dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

A. **Requirements for Coverage**

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

1. The individual elects coverage;
2. The individual is entitled to Medicare, if Medicare Complementary coverage applicable;
3. The Group accepts the individual's election and notifies CareFirst; and
4. Payments are made on behalf of the Member by the Group.

B. **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section B.1., and as stated in the Termination of Coverage section of the Evidence of Coverage.

When an Employee enrolls a Dependent in the Plan, the enrollment constitutes a representation by the Employee that the individual meets the definition of a Dependent and is eligible for the Plan, and that the Employee will provide evidence of eligibility on request. The enrollment also constitutes an acknowledgement by the Employee that the Plan is relying on the Employee's representation of eligibility in accepting the enrollment of the Dependent. If the Employee fails to provide evidence of eligibility when requested, that failure is evidence of fraud and material misrepresentation and the Plan may terminate coverage for the individual, which termination may be retroactive to the date as of which the individual first become ineligible.

1. **Open Enrollment Period**

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

- a. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
- b. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

2. **Newly Eligible Subscriber**

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period or a special enrollment period.

3. **Special Enrollment Periods**

Special enrollment is allowed for certain individuals in conjunction with: (1) a loss of other coverage, (2) the acquisition of certain Dependent beneficiaries or (3) losing eligibility for Medicaid or CHIP coverage, or gaining eligibility for premium assistance under Medicaid or CHIP. The Subscriber or individual seeking special enrollment must provide notice within the time period described in the Eligibility Schedule. Enrollment will be effective as stated in the Eligibility Schedule.

These special enrollment periods are not the same as Medicare special enrollment periods.

If only the Subscriber is eligible under this Evidence of Coverage and Dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

If retirees are eligible for coverage under this Evidence of Coverage, references to an employee shall be construed to include a retiree, except for references made in the context of special enrollment for certain individuals who lose coverage, as special enrollment for certain individuals who lose coverage is not applicable to retirees.

a. Special enrollment for certain individuals who lose coverage:

- 1) CareFirst will permit current employees and Dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
- 2) Individuals eligible for special enrollment.
 - a) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:
 - (1) The employee and the Dependents are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
 - (3) The employee satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - b) When Dependent loses coverage. A Dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:
 - (1) The Dependent and the employee are otherwise eligible to enroll;
 - (2) When coverage was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and

- (3) The Dependent satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.
 - (4) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph B.3.a.2)b), or the employee satisfies the criteria of paragraph B.3.a.2)a) of this section.
- 3) Conditions for special enrollment.
 - a) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph B.3.a.3)a) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:
 - (1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
 - (2) In the case of coverage offered through a health maintenance organization, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
 - (3) In the case of coverage offered through a health maintenance organization, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual; and
 - (4) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

- b) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.
 - c) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph B.3.a.3)a) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.
 - d) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)
- 4) Applying for special enrollment and effective date of coverage. The Group or CareFirst will allow an employee a period of at least thirty (30) days after an event described above to request enrollment (for the employee or the employee's Dependent).
- a) Coverage will begin no later than the first day of the first (1st) calendar month beginning after the date the Group or CareFirst receives the request for special enrollment.

- b. Special enrollment with respect to certain Dependent beneficiaries:
- 1) Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2), of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
 - 2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph B.3.a.2)a), b), c), d), e), or f) of this section.
 - a) Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption.
 - b) Spouse of a participant only. An individual is described in this paragraph if either:
 - (1) The individual becomes the spouse of a participant; or
 - (2) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.
 - c) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:
 - (1) The employee and the spouse become married; or
 - (2) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.
 - d) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.
 - e) Current employee and a new Dependent. A current employee and an individual who is a Dependent of the employee, are described in this paragraph if the individual becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.
 - f) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the Dependent becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.

- c. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

CareFirst will permit an employee or Dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

- 1) Termination of Medicaid or CHIP coverage. The employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.
- 2) Eligibility for employment assistance under Medicaid or CHIP. The employee or Dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

MEDICAL CHILD SUPPORT ORDERS

A. Definitions

1. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
 - a. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
 - b. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
2. Qualified Medical Support Order (QMSO) means a MCSO issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended.

B Eligibility and Termination

1. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage the child will not be enrolled until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.
2. Enrollment for such a child will not be denied because the child:
 - a. Was born out of wedlock.
 - b. Is not claimed as a Dependent on the Subscriber's federal tax return.
 - c. Does not reside with the Subscriber.
 - d. Is covered under any Medical Assistance or Medicaid program.

3. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
 - a. The MCSO/QMSO is no longer in effect;
 - b. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or
 - c. If coverage is provided under an employer sponsored health plan;
 - 1) The employer has eliminated family member's coverage for all employees; or
 - 2) The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable state or federal law, the child will continue in this post-employment coverage.

C. **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

1. Send the non-insuring custodial parent ID cards, claims forms, the applicable evidence of coverage or member contract and any information needed to obtain benefits;
2. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
3. Provide benefits directly to:
 - a. The non-insuring parent;
 - b. The Health Care Provider of the Covered Services; or
 - c. The appropriate child support enforcement agency of any state or the District of Columbia.

TERMINATION OF COVERAGE

A. Disenrollment of Individual Members

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons:

1. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.
2. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.
3. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.
4. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.
5. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.
6. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

B. Death of a Subscriber

If Dependent coverage is available, in the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

C. Effect of Termination

No benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

D. Reinstatement

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

A. Continuation of Eligibility upon Loss of Group Coverage

1. **Federal Continuation of Coverage under COBRA**

If the Group health benefit Plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit Plan may be possible. The employer offering this Group health benefit Plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the Plan Administrator.

2. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

COORDINATION OF BENEFITS; SUBROGATION

A. Coordination of Benefits

1. Applicability

- a. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
- b. If this COB provision applies, the Order of Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
 - 1) Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; and
 - 2) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is explained in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

2. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Evidence of Coverage.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

- a. An individually underwritten and issued, guaranteed renewable, specified disease policy, or specified accident policy;
- b. An intensive care policy, which does not provide benefits on an expense incurred basis;
- c. Coverage regulated by a motor vehicle reparation law;
- d. Any hospital indemnity or other fixed indemnity coverage contract;
- e. An elementary and/or secondary school insurance program sponsored by a school or school system and any school accident-type coverage that covers for accidents only, including athletics injuries;
- f. Medicare supplemental policies;
- g. Limited benefit health coverage as defined by state law;
- h. Long-term care insurance policies for non-medical services;
- i. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.
- j. A state plan under Medicaid; or
- k. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

- a. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- b. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- c. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

3. **Order of Benefit Determination Rules**

a. **General**

When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- 1) The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
- 2) Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

b. **Rules**

This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

- 1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- a) Secondary to the Plan covering the person as a Dependent; and
- b) Primary to the Plan covering the person as other than a Dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering the person as other than a Dependent.

- 2) Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a Dependent, the order of benefits shall be determined as follows:

- a) For a Dependent child whose parents are married or are living together:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
 - (2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

b) For a Dependent child whose parents are separated, divorced, or are not living together:

- (1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but the parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in 3.b.2)a) above also shall apply if: i) a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the Dependent child.

- (2) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- (a) The Plan of the parent with custody of the child;
- (b) The Plan of the spouse of the parent with the custody of the child;
- (c) The Plan of the parent not having custody of the child; and then
- (d) The Plan of the spouse of the parent who does not have custody of the child.

c) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in a) and b) of this paragraph as if those individuals were parents of the child.

3) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a Dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

- 4) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:
 - a) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's Dependent);
 - b) Second, the benefits under the continuation coverage.If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 5) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

4. **Effect on the Benefits of this CareFirst Plan**

a. **When this Section Applies**

This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

b. **Reduction in this CareFirst Plan's Benefits**

When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

5. **Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.

6. **Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

7. **Right of Recovery**

If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

B. **Employer or Governmental Benefits**

Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
2. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

C. **Subrogation**

1. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:
 - a. Caused by an act or omission of a third party; or
 - b. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or
 - c. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose. CareFirst will not subrogate a recovery made under Personal Injury Protection policy benefits.
2. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Evidence of Coverage, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid in benefits up to the amount received from or on behalf of the third party. CareFirst will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.

3. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.
4. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

For purposes of this provision, "made whole" means that the Member fully recovers all of their damages.

5. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Evidence of Coverage. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.
6. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in the “Choosing a Provider” subsection below. Other factors that may affect payment are found in Referrals, COB, Subrogation, the Inter-Plan Arrangements Disclosure, Inter-Plan Programs Ancillary Services, Exclusions, and Utilization Management Requirements.

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

- a. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider contracts with CareFirst or not relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.
- b. CareFirst makes payment for Covered Services but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Preferred Health Care Providers

- a. If a Member chooses a Preferred Health Care Provider, the cost to the Member is lower than if the Member chooses a Non-Preferred Health Care Provider. Throughout the Schedule of Benefits, payments are listed as either “in-network” (for a Preferred Health Care Provider) or “out-of-network” (for a Non-Preferred Health Care Provider).

If a Preferred Health Care Provider refers a Member to a Non-Preferred Health Care Provider, CareFirst will pay the in-network benefit, but the Member will still be responsible for the difference between CareFirst’s payment and the Non-Preferred Health Care Provider’s charge.

- b. Claims will be submitted directly to CareFirst by the Preferred Health Care Provider.
- c. CareFirst will pay benefits directly to the Preferred Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.
- d. The Member is responsible for any applicable Deductible and Coinsurance or Copayment, as stated in the Schedule of Benefits.

3. Non-Preferred Health Care Providers
 Except as otherwise authorized by CareFirst, if a Member chooses a Non-Preferred Health Care Provider, Covered Services may be eligible for reduced benefits. When Covered Services are provided by a Non-Preferred Health Care Provider, out-of-network benefits apply.
 - a. Claims may be submitted directly to CareFirst or its designee by the Non-Preferred Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
 - b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Preferred Health Care Provider, at the discretion of CareFirst.
 - c. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the appropriate department of an appropriate State (as designated in the order or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.
 - d. Non-Preferred Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Preferred Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Member is responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.
4. Ambulance Services Providers
 - a. For purposes of calculating the Member payment for Ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide	
If a Member receives Covered Services from:	Member liability:
Preferred Ambulance Services Provider	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Ambulance Services Provider	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits <u>and</u> for the difference between the Allowed Benefit and the Non-Preferred Ambulance Services Provider's actual charge.

- b. If a Member receives services from a Preferred Provider, the cost to the Member is lower than if the Member receives services from a Non-Preferred Provider.

C. Notice of Claim

A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

D. Claim Forms

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

E. Proofs of Loss

In order to receive benefits for services rendered by a Health Care Provider who does **not** contract with CareFirst, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

1. Claims for medical benefits must be submitted within twelve (12) months following the dates services were rendered.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the member, not later than one year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

F. Time of Payment of Claims

Benefits payable under this Evidence of Coverage will be paid not more than thirty (30) days after receipt of written proof of loss.

G. Claim Payments Made in Error

If CareFirst makes a claim payment to or on behalf of a Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

H. Assignment of Benefits

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Preferred Health Care Provider rendering Covered Services. A Member may not assign his or her right to bring a lawsuit under ERISA against Perdue, the Plan, the Plan Administrator, or CareFirst.

I. Evidence of Coverage

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable. Only one statement will be issued for each family unit.

J. Notices

Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail or by first class mail to the most recent address for the Member in CareFirst's files. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

K. **Privacy Statement**

CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

L. **Prescription Drug Rebate Sharing**

CareFirst may be eligible for rebates from Prescription drug manufacturers upon negotiating directly with manufacturers.

CareFirst and the Plan Sponsor, as such is defined in the Administrative Services Agreement, agree to the extent to which any such rebates are shared.

REFERRALS

Referral Requirements

- A. Written referrals are not required.
- B. Referral to a Specialist or Non-Physician Specialist
1. Non-Physician Specialist means a Health Care Provider who is not a physician who is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any state or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.
 2. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and
 - a. CareFirst does not contract with a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
 - b. CareFirst cannot provide reasonable access to a contracted specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
 3. For purposes of calculating any Member payment, CareFirst will treat the services provided by the Specialist or Non-Physician Specialist as if the services were provided by a Preferred Health Care Provider.
- C. Referrals Quick Reference

While written referrals are not required, Covered Services with a referral will be available as follows:

For Covered Services:			
If a Member sees a:	With referral:	Without referral:	Member liability:
Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.		No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Preferred Health Care Provider	Covered Services will be paid at the in-network level of benefits.	Covered Services will be paid at the out-of-network level of benefits if out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted for Covered Services: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits and for the difference between the Allowed Benefit and the Non-Preferred Health Provider's actual charge.

This Referrals Quick Reference guide is subject to the terms stated in the Referral to a Specialist or Non-Physician Specialist section, above.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

Most Prescription Drugs classified as Specialty Drugs require prior authorization; prior authorization applies to Specialty Drugs covered under the medical portion of this Evidence of Coverage (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings). Specialty Drugs are defined in the Definitions section of this Evidence of Coverage. Preferred Health Care Providers will obtain prior authorization from CareFirst on behalf of the Member. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization/a Plan of Treatment. Failure to obtain prior authorization may result in denial of the claim.

A. Plan of Treatment

Certain outpatient services indicated throughout this Evidence of Coverage require CareFirst's approval of a Plan of Treatment before benefits for Covered Services are provided; a penalty may apply if such approval is not obtained.

1. A health care practitioner must complete and submit a Plan of Treatment.
2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.
3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.
4. Within the Service Area, a Preferred Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Preferred Health Care Provider or a Non-Preferred Health Care Provider.
5. Services for which CareFirst must approve a Plan of Treatment:
 - a. Controlled Clinical Trial Patient Cost coverage

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
 - b. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

c. Home Health Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late (forty-eight (48) hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

d. Hospice Care

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing hospice care, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

e. Private Duty Nursing

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

B. Hospital Pre-Certification and Review

A Preferred Health Care Provider, in and out of the Service Area, will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Preferred Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

- a. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.
- b. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.
- c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.
- d. Pre-operative days will not be approved for procedures unless Medically Necessary.
- e. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.
- f. CareFirst's payment will be based on the inpatient days approved by the reviewer.
- g. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.

- h. Hospital Pre-Certification and Review is not applicable to maternity admissions, and admissions for cornea and kidney transplants.
2. Non-Emergency (Elective) Admissions
- a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.
 - b. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.
 - c. CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - d. For Out-of-Network Covered Services:
 - 1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
 - 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.
3. Emergency (Non-Elective) Admissions
- a. The Member, the Health Care Provider or another person acting on behalf of the Member must notify the reviewer within twenty-four (24) hours following the Member's admission, or as soon thereafter as reasonably possible.

The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify the reviewer of the emergency admission within twenty-four (24) hours if the Member's medical condition prevented the hospital from determining:

 - 1) The Member's insurance status; and
 - 2) The reviewer's emergency admission notification requirements.
 - b. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:
 - 1) During the first twenty-four (24) hours the Member is in an inpatient facility; or
 - 2) Until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a Member has been admitted and shall state the reasons for the admission.

- c. The reviewer will make all initial determinations on whether to approve a non-elective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

For non-elective admissions for which the reviewer receives notice but does not approve inpatient benefits, CareFirst will notify the hospital attending Health Care Provider that inpatient benefits will not be paid as of the date of notification.

- 1) A Member will have to pay:
 - a) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.
 - b) Non-Preferred Health Care Providers if a non-elective admission results in payment denial.
- 2) A Member will not have to pay Preferred Providers:
 - a) If the Member is admitted and the admission is not Medically Necessary;
 - b) If a non-elective admission results in payment denial.

- d. For Out-of-Network Covered Services:

- 1) CareFirst will not provide benefits for a non-elective admission which is not Medically Necessary. The Member is responsible for the entire admission.
- 2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the non-elective admission was Medically Necessary:
 - a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 50%;
 - b) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

- 4. Continued Stay Review
The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.
- 5. Discharge Planning
The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.

6. Program Monitoring
 - a. The Member's medical record will be reviewed by the reviewer.
 - b. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.
 - c. During and after discharge, the reviewer may review the medical records to:
 - 1) Verify that the services are covered under the Evidence of Coverage;
 - 2) Ensure that the Health Care Provider is substantially following the Plan of Treatment.
7. Notice and Appeals
 - a. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.
 - b. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.
 - 1) If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.
 - 2) For instructions on how to appeal an Adverse Decision, refer to the Claims Procedures of this Evidence of Coverage.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services

Overview

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan. The Inter-Plan Programs are described generally below.

When a Member receives care outside of CareFirst’s service area, it will be received from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. CareFirst explains below how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst’s service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst’s service area and care received outside the geographic area CareFirst serves is stated in the Definitions.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when a Member receives Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When a Member receives Covered Services outside CareFirst’s service area and the claim is processed through the BlueCard Program, the amount a Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount a Member pays for Covered Services under this arrangement will be calculated based on the negotiated price/lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to a Member, the Member will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, a Member will incur no liability, other than any related Member cost sharing.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside CareFirst's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount a Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, a Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

E. **Blue Cross Blue Shield Global Core Program**

If a Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), the Member may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit Member claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **Members must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Members pay for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submission, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs); and
2. Medical Devices and Supplies.

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. Member Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider or a Health Care Provider who contracts with the local Blue Cross and/or Blue Shield Licensee in that geographic area as stated in the Inter-Plan Arrangements Disclosure.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. Determining the Local Plan

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: <ul style="list-style-type: none">• Shipped to; or• Purchased at a retail store.	

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE (Medicare Complementary)

The provisions in this section apply to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in this Evidence of Coverage. Benefits that are covered by Medicare are subject to the provisions in this section.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures; however, the Utilization Management Requirements of this Evidence of Coverage do not apply to persons for whom Medicare is the primary carrier.

Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Providers contracted with CareFirst, all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

This coverage is not Medicare supplemental coverage. This coverage provides benefits for some charges and services not covered by Medicare. It is not designed to fill the "gaps" of Medicare.

Covered Services under Medicare Complementary are the same as under the Description of Covered Services. Only the manner of payment is different:

A. Coverage Secondary to Medicare

Except where prohibited by law, CareFirst benefits are secondary to Medicare.

B. Medicare as Primary

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare:
 - a. For any Health Care Provider who accepts Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge.
 - b. For any Health Care Provider who does not accept Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the limitation set by Medicare.
2. **For a Member who Elects Medicare Part B:** CareFirst will coordinate as described above and pay benefits based on Medicare's payment. For example, after meeting the Part B deductible, Medicare pays 80% of the Medicare approved amount for most doctor services; the basis for CareFirst's payment is the remaining 20% of the Medicare approved amount (the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge/limitation set by Medicare).

- a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming:	
Part B deductible has been met; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%; and Medicare approved charge does not exceed limitation set by Medicare, if applicable	
Medicare approved amount	\$ 1,000.00
Multiplied by 80% equals Medicare payment	\$ 800.00
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

3. **For a Member who Does not Elect Part B:** CareFirst will reduce its payment to “carve-out” or reject the 80% coinsurance Medicare would have paid if the Member had elected Part B.
- a. If the amount Medicare would have paid is available, CareFirst will coordinate as described above, “carving-out” or rejecting the amount Medicare would have paid. CareFirst will base its reduced Coinsurance payment on the amount Medicare would have paid if the Member had elected Part B.
- b. If the amount Medicare would have paid is not available, CareFirst will base its Coinsurance payment on 20% of the Allowed Benefit. The 80% reduction to the Allowed Benefit represents the amount that Medicare theoretically would have paid if the Member had elected Part B.
- c. Numerical Examples for a Member who Does not Elect Part B:
- 1) In the first numeric example below, CareFirst's Allowed Benefit is assumed to be the same as the Medicare approved amount in the above example for a Member who elects Medicare Part B. In this example, CareFirst's payment does not differ; however, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 1,000.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 160.00

- 2) In the second numeric example below, CareFirst's Allowed Benefit is assumed to differ from the Medicare approved amount in the above example for a Member who elects Medicare Part B. Again, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	\$ 500.00
Medicare payment	\$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	\$ 100.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	\$ 100.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	\$ 80.00

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists other features that affect Member coverage, including, if applicable, the Deductible, Out-of-Pocket Maximum, and specific benefit limitations. It is also important to review the section entitled "Exclusions."

PREVENTIVE AND WELLNESS SERVICES

A. Covered Services:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).
 - a. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.
 - b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.
 - c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
2. If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.
3. CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

**AMBULANCE SERVICES
(NON-EMERGENCY)**

A. Covered Services

1. Medically Necessary, non-emergency air transportation, surface, and ground ambulance services, as determined by CareFirst.

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Is approved by:
 - a. The National Institutes of Health (NIH) or a Cooperative Group.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - 1) To be comparable to the system of peer review of studies and investigations used by the NIH, and
 - 2) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - h. The FDA in the form of an investigational new drug application.
 - i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Evidence of Coverage for non-Investigational treatments.

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:
 - a. Treatment provided for a life-threatening condition; or,
 - b. Prevention, early detection, and treatment studies on cancer.
2. Coverage will be provided only if:
 - a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer; or,
 - b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;
 - c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,
 - e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.
 - f. Prior authorization has been obtained from CareFirst.
3. Coverage is provided for the Patient Cost, including Patient Cost, incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

DIABETES EQUIPMENT

Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

DIABETES SUPPLIES

Coverage will be provided for all Medically Necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

DIABETES SELF-MANAGEMENT TRAINING

1. Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
2. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

1. With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the Member.
2. Medically Necessary, emergency air transportation, surface, and ground ambulance services, as determined by CareFirst.
3. Urgent Care services.

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:
 - a. If the Member is:
 - 1) Seven years of age or younger, or developmentally disabled;
 - 2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and
 - 3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - b. Or, if the Member is:
 - 1) Seventeen years of age or younger;
 - 2) An extremely uncooperative, fearful, or uncommunicative individual;
 - 3) An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - 4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - c. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - d. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - 1) A fully accredited specialist in pediatric dentistry;
 - 2) A fully accredited specialist in oral and maxillofacial surgery; and
 - 3) A dentist who has been granted hospital privileges.
 - e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

HOME HEALTH CARE

A. Definitions

Home Health Care means the continued care and treatment of a Member by a Health Care Provider in the home if:

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and
2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

Home Health Care Visits means:

1. Each visit by a member of a Home Health Care team is considered one Home Health Care Visit; and
2. Up to four (4) hours of Home Health Care service is considered one Home Health Care visit.

B. Covered Services

1. Home Health Care, as defined above.
2. Home Visits Following Childbirth, including any services required by the attending Health Care Provider:
 - a. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or ninety-six (96) hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;
 - b. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):
 - 1) One home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge;
 - 2) An additional home visit following childbirth if prescribed by the attending Health Care Provider.
 - c. An attending Health Care Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Health Care Provider, attending the Member or newborn Dependent child(ren).
 - d. Home visits following childbirth must be rendered, as follows:
 - 1) In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
 - 2) By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

3. Home Visits Following the Surgical Removal of a Testicle
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - 1) One home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and
 - 2) An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

C. Limitations

1. The Member must be confined to “home” due to a medical condition. “Home” cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.
2. The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. “Skilled Nursing Care,” for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.
4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).
5. See additional limitations in the Schedule of Benefits.

HOSPICE CARE

A. Definitions

Caregiver means a person who is not a Health Care Provider who lives with or is the primary caregiver of the Member in the home. The Caregiver can be a relative by blood, marriage or adoption or a friend of the Member, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

1. Inpatient hospice facility services;
2. Part-time nursing care by or supervised by a registered graduate nurse;
3. Counseling, including dietary counseling, for the Member;
4. Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the Member;
5. Medical care by the attending physician;
6. Other Medically Necessary health care services at CareFirst's discretion.

Additionally, hospice care benefits are available for a Member's family (family is the spouse, parents, siblings, grandparents, child(ren), and/or Caregiver) for periodic family counseling before the Member's death, and bereavement counseling.

A Member, or representative of the Member, can petition CareFirst to review the Member's case and authorize an extension of coverage. CareFirst reserves the right to extend the hospice care eligibility period for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care, if it determines that the patient's prognosis and continued need for services are consistent with a program of hospice care. Additional "reserve" benefits (up to 45 days) apply if the Member exceeds: the Hospice Eligibility Period and/or the inpatient benefit limit.

INFERTILITY SERVICES

A. Definitions

Infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.

B. Covered Services

1. Benefits are available for the diagnosis of Infertility excluding artificial insemination/intrauterine insemination and in vitro fertilization.
2. Under the Prescription Drug Coverage (see APPENDIX A), benefits are available for fertility drugs, up to a lifetime maximum of \$10,000. Benefits are not otherwise available for the treatment of Infertility.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(ambulatory services; hospitalization; laboratory services)

A. Covered Services

1. Inpatient/outpatient medical care and consultations.

Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Health Care Provider and a Member. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

2. Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

3. Surgery, as follows:

a. Oral surgery, limited to:

- 1) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity not solely involving teeth.
- 2) Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

- 1) The injury did not arise while or as a result of biting or chewing; and
- 2) Treatment is commenced within twelve (12) months of the injury or, if due to the nature of the injury treatment could not begin within twelve (12) months of the injury, treatment began within twelve (12) months of the earliest date that it would be medically appropriate to begin such treatment.

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

- b. Medically Necessary surgical procedures, as determined by CareFirst.

If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

- 1) If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.
- 2) If the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

- c. Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are (i) Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention, or (ii) described in the following section, entitled "Mastectomy Related Services.

4. Inpatient/outpatient assistant if the surgery requires surgical assistance as determined by CareFirst.
5. Inpatient/outpatient anesthesia services by a Health Care Provider other than the operating surgeon.
6. Inpatient/outpatient chemotherapy.
7. Home Infusion Therapy.
8. Inpatient/outpatient radiation therapy.
9. Inpatient/outpatient renal dialysis.
10. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
11. Administration of injectable Prescription Drugs by a Health Care Provider.
12. Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), allergy testing.
13. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.

14. Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from oral surgery, and otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.
15. Elective sterilization.
16. Skilled Nursing Facility services.
17. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
18. Treatment of temporomandibular joint (TMJ) dysfunction: Medically Necessary conservative treatment and surgery, as determined by CareFirst.
19. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
2. Breast prostheses prescribed by a physician for a Member who has undergone a mastectomy and has not had breast reconstruction;
3. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member;
4. Inpatient hospital services for a minimum of forty-eight (48) hours following a mastectomy as a result of breast cancer. A Member may request a shorter length of stay if the Member decides, in consultation with the attending physician, that less time is needed for recovery.
 - a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - 1) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
 - 2) An additional home visit if prescribed by the Member's attending physician.
 - b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician.

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services, including:

a. Maternity services:

- 1) Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:
 - a) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support, supplies and consultation as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration; and
 - b) Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration.
- 2) Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not specifically identified above, and Ancillary Services provided during those visits. These benefits include Medically Necessary laboratory diagnostic tests and services not identified above, but are not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
- 3) Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event.

b. Newborn care services, as follows:

- 1) Medically Necessary services for the normal newborn (an infant born at approximately forty (40) weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
- 2) Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;
- 3) Circumcision.

- c. Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - 1) A minimum of:
 - a) Forty-eight (48) hours following an uncomplicated vaginal delivery;
 - b) Ninety-six (96) hours following an uncomplicated cesarean section.
 - 2) Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.
- 3. Coverage for victims of rape or incest.
- 4. Birthing classes: One (1) course per pregnancy at a CareFirst approved facility.
- 5. Birthing centers.
- 6. Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
- 7. Benefits are available for comprehensive lactation support and counseling, by a Health Care Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

1. Is primarily and customarily used to serve a medical purpose;
2. Is not useful to a person in the absence of illness or injury;
3. Is ordered or prescribed by a physician or other qualified practitioner;
4. Is consistent with the diagnosis;
5. Is appropriate for use in the home;
6. Is reusable; and
7. Can withstand repeated use.

Medical Device means Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

1. Are primarily and customarily used to serve a medical purpose;
2. Are not useful to a person in the absence of illness or injury;
3. Are ordered or prescribed by a physician or other qualified practitioner;
4. Are consistent with the diagnosis;
5. Are appropriate for use in the home;
6. Cannot withstand repeated use; and
7. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
4. May be purely passive support or may make use of spring devices;
5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a Health Care Provider; and
5. Is removable and attached externally to the body.

B. Covered Services

1. **Durable Medical Equipment**

Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

2. **Hair Prosthesis**

Benefits are available for a hair prosthesis for treatment of cancer.

3. **Medical foods and nutritional substances**

Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

4. **Medical Supplies**

Benefits are available for Medical Supplies as such supplies are defined above.

5. **Orthotic Devices, Prosthetic Devices**

Benefits include:

- a. Supplies and accessories necessary for effective functioning of the Orthotic or Prosthetic Device;
- b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
- c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

- d. **Repairs.** Benefits for the repair, maintenance or replacement of an Orthotic or Prosthetic Device require authorization or approval by CareFirst. Benefits are limited to:
- 1) Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.
 - 2) Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.
 - 3) Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

**MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES,
INCLUDING BEHAVIORAL HEALTH TREATMENT**

Inpatient/outpatient mental health and substance use disorder services, including behavioral health treatment.

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

Donor Services consist of services covered under the Evidence of Coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Recipient/Donor Services

When Member is a:	Benefits are available for:
Recipient	Benefits are available for both the Member recipient and the non-Member donor. Donor benefits are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services.

Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/ Investigational as determined by CareFirst.
2. Donor Services, limited to the extent stated above.
3. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.
4. Immunosuppressant maintenance drugs when prescribed for a covered transplant.
5. Organ transplant procurement benefits for the recipient, as follows:
 - a. Health services and supplies used by the surgical team to remove the donor organ.
 - b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.
 - c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
6. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;
2. Conform to all laws that apply to organ transplants; and
3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;
2. Diagnosis;
3. Type of surgery; and
4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

Benefits are available for Medically Necessary outpatient Private Duty Nursing, as determined by CareFirst. Benefits are not provided for Private Duty Nursing rendered in a hospital.

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
<p>Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs.</p> <p>Benefits are available through Express Scripts for Pharmacy-dispensed Prescription Drugs. Please see Appendix A at the end of this Evidence of Coverage for a description of the Prescription Drug Program.</p>	<p>Benefits are available, and limited to, Prescription Drugs dispensed in the office of a Health Care Provider.</p> <p>Contraceptives: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.</p>

PROFESSIONAL NUTRITIONAL COUNSELING/MEDICAL NUTRITION THERAPY

A. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

B. Covered Services

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

REHABILITATIVE AND HABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**

Benefits are available for inpatient Rehabilitative Services.

2. **Outpatient Rehabilitative Services**

Benefits are available for the following outpatient Rehabilitative Services:

a. Occupational Therapy;

b. Physical Therapy; and

c. Speech Therapy.

3. **Cardiac Rehabilitation**

Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation.

Benefits will not be provided for maintenance programs.

4. **Habilitative Services**

Benefits are available for outpatient Habilitative Services.

5. **Pulmonary Rehabilitation**

Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation.

Benefits will not be provided for maintenance programs.

6. **Visual Therapy**

Benefits are available for outpatient visual therapy.

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Preferred Health Care Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
 2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
 3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including: flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
 - Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
 - Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).
 - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
 - All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the Member, unless otherwise a Covered Service.

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.
- Any procedure or treatment designed to alter an individual’s physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to health education classes and self-help programs, except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary and/or cardiac rehabilitation programs and services provided by the Group’s Designated Wellness Services Provider.
- Medical or surgical treatment for obesity, unless otherwise specified in the Description of Covered Services.
- Medical or surgical treatment or regimen for reducing or controlling weight for morbid obesity.

These exclusions do not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.

- Routine vision examinations, including but not limited to external examination of the eye and adnexa, ophthalmoscopic examination, determination of refractive status, binocular balancing testing, tonometry test for glaucoma, gross visual field testing, and color vision testing.
- Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses.
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.
- Non-medical Health Care Provider services, including, but not limited to:
 1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
 2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider’s medical practices services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.

- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.
- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).
- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.

- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.
- Immunizations solely for foreign travel.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in the Description of Covered Services.
- Hearing care except as otherwise stated.
- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.
- Work Hardening Programs. Work Hardening Programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

Ambulance (Non-Emergency) Services

- Except Medically Necessary, non-emergency ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

Emergency Services

- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

General anesthesia and associated hospital or ambulatory surgical facility services for dental care

- Dental care for which general anesthesia is provided.

Home Health Care

- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.
- Respite care.

Infertility Services

- Medical or surgical treatment for Infertility, except as stated in the Description of Covered Services.

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.
- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.
- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).
- Acupuncture.
- Inpatient Private Duty Nursing.
- Procedures to reverse sterilization.
- Surgical removal of impacted teeth.
- Elective Abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother or expenses are incurred to treat medical complications due to the abortion or the pregnancy is the result of rape or incest.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Medical Supplies, except as stated in the Description of Covered Services, or any riders attached to this Evidence of Coverage.
- Orthotic Devices and Prosthetic Devices, except as stated in the Description of Covered Services.
- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

Mental health and substance use disorder services, including behavioral health treatment

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses Incurred for the location of a suitable donor; e.g., search of a population or mass screening.

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services or Appendix A.
- Routine immunizations and boosters (except as stated in the Description of Covered Services, Preventive and Wellness Services).

Rehabilitative and Habilitative Services

- Services delivered through early intervention and school services.
- Applied Behavioral Analysis services.

ELIGIBILITY SCHEDULE

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group.	
Spouse	Coverage for a Dependent spouse is available.	
Domestic Partner	Coverage for Domestic Partners is not available.	
Dependent children	Coverage for Dependent children, excluding children of a Domestic Partner, is available.	Limiting Age Up to age 26
Unmarried, incapacitated Dependent children	<p>A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:</p> <ol style="list-style-type: none"> 1. The Dependent child is chiefly Dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty (30) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated. 	Limiting Age Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES OF COVERAGE	
Open Enrollment	The Group's Contract Date is the effective date of Coverage.
Newly eligible Subscriber	<p>A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.</p> <p>A Subscriber who is not enrolled when the Group receives a QMSO is eligible for coverage effective on the date specified in the MCSO.</p>
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Newly eligible Dependents of a Subscriber	<p>1. For a newborn Dependent, newly adopted Dependent child, newly eligible Dependent child, a minor Dependent child for whom Guardianship is granted by Court or Testamentary Appointment, coverage is effective as follows:</p> <ol style="list-style-type: none"> If the Subscriber's Type of Coverage is "Family" Type of Coverage on the Dependent child's First Eligibility Date, the Dependent child will be covered automatically effective as of the child's First Eligibility Date, stated below. If the Subscriber's Type of Coverage is "Individual" Type of Coverage as of the Dependent child's First Eligibility Date stated below, the Dependent child will be covered automatically <u>only</u> for the first thirty-one (31) days following the Dependent child's First Eligibility Date. However, if the Subscriber wishes to continue the child's coverage beyond the automatic thirty-one (31) day period, the Subscriber must enroll the Dependent child within thirty-one (31) days of the child's First Eligibility Date. If the Subscriber's Type of Coverage is "Individual and Adult" or "Individual and child" Type of Coverage as of the Dependent child's First Eligibility Date stated below, the Dependent child will be covered automatically as of the Dependent child's First Eligibility Date. However, if the addition of the Dependent child results in a change in the Subscriber's Type of Coverage (e.g., from "Individual and Adult" or "Individual and Child" coverage to "Family" coverage), the Dependent child's automatic coverage will end on the thirty-first (31st) day following the child's First Eligibility Date. If the Subscriber wishes to continue coverage beyond the automatic thirty-one (31) day period, the Subscriber must enroll the Dependent child within thirty-one (31) days following the First Eligibility Date. "First Eligibility Date" means: <ol style="list-style-type: none"> For a newborn Dependent child, the child's date of birth. For a newly adopted Dependent child, the earlier of: <ol style="list-style-type: none"> A judicial decree of adoption; or Placement of the Dependent child in the Subscriber's home as the legally recognized proposed adoptive parent. For newly eligible Dependent child, the date the Dependent child became a Dependent of Subscriber or the Subscriber's Dependent spouse. For a minor Dependent child for whom guardianship has been granted by court or testamentary appointment the date of the appointment.

EFFECTIVE DATES OF COVERAGE	
	2. All other newly eligible Dependents of a Subscriber must apply for coverage under this Evidence of Coverage as stated in the Special Enrollment Periods section of this Eligibility Schedule. Coverage for such newly eligible Dependents will be effective as stated in the Special Enrollment Periods section of this schedule.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage	<p>The employee must notify the Group, and the Group must notify CareFirst no later than thirty (30) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.</p>
Special enrollment for certain Dependent beneficiaries	<p>The employee must notify the Group, and the Group must notify CareFirst during the thirty (30) day special enrollment period beginning, as follows:</p> <p>In the case of marriage: the date of marriage (or, if Dependent coverage is not generally available at the time of the marriage, a period of thirty (30) days after Dependent coverage is made generally available by the Group).</p> <p>In the case of a newborn Dependent, newly adopted Dependent child, newly eligible Dependent child, a minor Dependent child for whom Guardianship is granted by Court or Testamentary Appointment: the enrollment period will be effective as stated in the Effective Dates of Coverage section of this schedule.</p>
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or Dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or Dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).</p> <p>A new Subscriber and/or his/her Dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.</p>

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the date eligibility ceases as determined by the Group.
Dependent child	<p>If the Subscriber enrolled the Dependent child within thirty-one (31) days of the child's First Eligibility Date:</p> <p>The Dependent child will remain covered until the birthday when the Dependent child reaches the Limiting Age for a Dependent child.</p> <p>If the Subscriber did not enroll the Dependent child within thirty-one (31) days of the child's First Eligibility Date:</p> <p>The Dependent child will remain covered until the end of the thirty-first (31st) day following the Dependent child's First Eligibility Date, as such is stated in the Effective Dates of Coverage section of this schedule.</p>
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the date eligibility ceases as determined by the Group.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.
Subscriber changes the Type of Coverage to an Individual or other non-family contract (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Coverage will terminate on the date the Subscriber changes the Type of Coverage to an Individual or other non-family contract.
Death of a Subscriber	Coverage of any Dependents will terminate on the date determined by the Group.

SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced. See Utilization Management Requirements for these rules.

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

DEDUCTIBLE			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$600	\$1,500	\$1,500	\$3,000
Applicable to all in-network benefits, except as stated in the Description of Covered Services.		Applicable to all out-of-network benefits, except as stated in the Description of Covered Services.	
In-Network and Out-of-Network			
The in-network and out-of-network Deductible will be a combined amount.			
The Deductible is calculated based on the Allowed Benefit of Covered Services.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Deductible, then for the remainder of the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Deductible and the Family Deductible apply. If the Family Deductible has not been met for the Benefit Period, then a Member must meet the Individual Deductible before CareFirst will pay the benefit amounts specified in the Schedule of Benefits for that Member. If the Family Deductible has been met for the Benefit Period, CareFirst will pay the benefit amounts specified in the Schedule of Benefits for all covered family Members.			
The following amounts apply to the Deductible:		The following amounts may <u>not</u> be used to satisfy the Deductible:	
- 100% of the Allowed Benefit for Covered Services that are subject to the Deductible.		- Charges in excess of the Allowed Benefit. - Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below. - Charges for Covered Services not subject to the Deductible. - Amounts paid by the Members for the Covered Services provided under the Pharmacy-dispensed Prescription Drugs as provided in Appendix A.	

OUT-OF-POCKET MAXIMUM			
In-Network		Out-of-Network	
Individual	Family	Individual	Family
\$5,000	\$10,000	\$10,000	\$17,000
In-Network and Out-of-Network			
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.			
If a Member is enrolled in Individual coverage (for example: employee-only) and meets the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for the remainder of the Benefit Period.			
If a Member is enrolled in anything other than Individual coverage (for example: employee-plus-spouse, employee-plus-children, or family), then both the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum apply. If a covered family Member has met the Individual Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for that Member for the remainder of the Benefit Period. If a covered family Member has not met the Individual Out-of-Pocket Maximum, but the family as a whole has met the Family Out-of-Pocket Maximum, CareFirst will pay 100% of the Allowed Benefit for all covered family Members for the remainder of the Benefit Period.			
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.			
The following amounts apply to the Out-of-Pocket Maximum:		The following amounts do <u>not</u> apply to the Out-of-Pocket Maximum:	
<ul style="list-style-type: none"> Coinsurance (Member's share). Copays. Deductible. Amounts paid by the Members for the Covered Services provided under the Pharmacy-dispensed Prescription Drugs as provided in Appendix A. 		<ul style="list-style-type: none"> Charges in excess of the Allowed Benefit. 	

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are not Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

IMPORTANT NOTE REGARDING THE ALLOWED BENEFIT FOR CERTAIN PROVIDERS
The Allowed Benefit for Covered Services will be the provider's actual charge for the following Health Care Providers:
<ul style="list-style-type: none"> Perdue Wellness Center Providers Omada Health Providers

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	90% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Adult preventive and wellness services (office visit)		
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	90% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Chlamydia screening	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Colorectal cancer screening		
Hepatitis C screening		
Human papillomavirus screening		
Mammography/breast cancer screening		
Osteoporosis prevention		
Prostate cancer screening		

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services	Limitations Ambulance services are limited, as follows: <ul style="list-style-type: none"> Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance. 	
Ambulance Services	90% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Limitations Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes equipment	90% of Allowed Benefit	70% of Allowed Benefit
Diabetes supplies		
Diabetes self-management training	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services		
Emergency Services in a hospital emergency room/department		
Hospital emergency room/department and ancillary services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	90% of Allowed Benefit after \$100 Copay*	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Outpatient professional practitioner(s) in hospital emergency room/department	90% of Allowed Benefit	Paid the same as in-network* *These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.
Member admitted as inpatient	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Hospital emergency room/department services for any condition that is not an Emergency Medical Condition	Please see “Medical care and consultations (illness visits)” table below.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay**	70% of Allowed Benefit
Urgent Care center	No Deductible required 100% of Allowed Benefit after \$30 Copay	70% of Allowed Benefit
Dental services related to accidental injury or trauma	90% of Allowed Benefit	70% of Allowed Benefit

*Copay waived if admitted.

**Copay applies to the office exam only.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
General anesthesia and associated hospital or ambulatory surgical facility services for dental care	Limitations An approved Plan of Treatment may be required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	Limitations An approved Plan of Treatment is required for Home Health Care. Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS) provided under the Total Care and Cost Improvement Program. Hospital/home health agency: Twenty (20) Home Health Care Visits per Benefit Period.	
	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care	Limitations An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and/or family. Benefits for Hospice care services are limited to a maximum two-hundred and forty (240) days per Benefit Period. Benefits for bereavement counseling are limited to three (3) visits within one year of the family member's death.	
	90% of Allowed Benefit*	

*These Out-of-Network services contribute to the In-Network Out-of-Pocket maximum.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services		
Infertility services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient hospital or health care facility	Limitations Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
Facility	90% of Allowed Benefit	50% of Allowed Benefit
Inpatient practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Skilled Nursing Facility	Limitations Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to sixty (60) days per Benefit Period combined with Inpatient rehabilitation. Admission must be within fourteen (14) days of a hospital confinement of at least three (3) days.	
	No Deductible required 90% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	90% of Allowed Benefit	50% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.	Benefits available to the same extent as benefits provided for in-network inpatient hospital or health care facility.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Cleft lip or cleft palate, or both		
Oral surgery		
Facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Otological, audiological and speech/language treatment		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	No prior authorization required for maternity admissions.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mastectomy-Related Services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	90% of Allowed Benefit	70% of Allowed Benefit
Hair prosthesis (Cancer diagnosis only)	Limitations Benefits for hair prosthesis are limited to \$500 per Benefit Period.	
	90% of Allowed Benefit	70% of Allowed Benefit
Medical foods and nutritional substances	90% of Allowed Benefit	70% of Allowed Benefit
Medical Supplies	90% of Allowed Benefit	70% of Allowed Benefit
Orthotic Devices, Prosthetic Devices	90% of Allowed Benefit	70% of Allowed Benefit
Treatment of temporomandibular joint dysfunction	Limitations Benefits for the treatment of temporomandibular joint dysfunction are limited to \$600 lifetime maximum.	
	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mental health and Substance Use Disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient Health Care Provider Services	Limitations Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services	Benefits for outpatient care are available, including: <ul style="list-style-type: none"> • Partial hospitalization; • methadone maintenance treatment; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy. 	
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	70% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit after \$30 Copay	70% of Allowed Benefit
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests and X-Rays		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	Paid the same as in-network
Office and/or independent laboratory	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit
Other diagnostic services		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	90% of Allowed Benefit	Paid the same as in-network
Office	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	Limitations Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services.	
Organ and tissue transplants and Related Services performed and/or provided at a Blue Distinction Center (BDC)	Organ/tissue transplant and services provided by a BDC for the first ninety (90) days from the date of transplant: No Deductible required 100% of Allowed Benefit Services provided by a BDC ninety (90) days after date of transplant: Benefit are available to the same extent as benefits provided for other illnesses.	No benefit
Organ and tissue transplants and transplant-related services provided by other providers (Non-Blue Distinction Centers)		
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel and lodging		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Services provided in an hospital emergency room for non-Emergency Medical Conditions and illness visits		
Hospital emergency room/department facility services	50% of Allowed Benefit after \$100 Copay* *Copay waived if Member is admitted.	
Outpatient professional practitioner services provided in a hospital emergency room/department	50% of Allowed Benefit	
Services provided in other places of service for non-Emergency Medical Conditions and illness visits		
Outpatient hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office/home	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit
Medical care and consultations at Perdue HealthWorks/Perdue Wellness Center		
Non-routine/non-preventive services	<u>Subscriber:</u> No Deductible required 100% of Allowed Benefit <u>Dependent:</u> No Deductible required 100% of Allowed Benefit after \$15 Copay	Not applicable
Preventive and wellness services and screenings	No Deductible required 100% of Allowed Benefit	Not applicable
Urgent Care center	Benefits are available to the same extent as benefits provided for Emergency Services provided in an Urgent Care facility.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Ambulatory surgical facility services	90% of Allowed Benefit	70% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	Paid the same as in-network
Surgical assistant		
Female elective sterilization	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Administration of injectable Prescription Drugs	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)		
Allergenic extracts (sera)		
Allergy testing		
Chemotherapy		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Home Infusion Therapy	90% of Allowed Benefit	70% of Allowed Benefit
Inhalation therapy		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Radiation therapy		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Renal dialysis		
Hospital	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Spinal manipulation	Limitations Spinal manipulation is limited to twenty-five (25) days per Benefit Period.	
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	Limitations An approved Plan of Treatment is required. No inpatient Private Duty Nursing benefits are available. Outpatient Private Duty Nursing is limited to twenty (20) days per Benefit Period.	
Facility/agency	90% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drugs	Limitations Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: <ul style="list-style-type: none"> allergenic extracts (allergy sera) injectable Prescription Drug contraceptives and contraceptive devices 	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy		
All outpatient places of service	No Deductible required 100% of Allowed Benefit after \$30 PCP Copay or \$50 Specialist Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Inpatient Rehabilitative Services	Limitations Hospital Pre-Certification and Review is required.	
	Inpatient facility rehabilitation is limited to sixty (60) days per Benefit Period, combined with Skilled Nursing Facility. Benefits are available to the same extent as inpatient benefits provided for other illnesses.	
Outpatient Rehabilitative Services		
Occupational Therapy	Limitations Occupational Therapy benefits are limited to twenty-five (25) days per Benefit Period.	
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Physical Therapy	Limitations Physical Therapy benefits are limited twenty-five (25) days per Benefit Period.	
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Speech Therapy	Limitations Speech Therapy benefits are limited to twenty-five (25) days per Benefit Period.	
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit
Cardiac Rehabilitation		
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Outpatient Rehabilitative Services		
Habilitative Services	Limitations Habilitative Services for autism or an autism spectrum disorder does not include Applied Behavioral Analysis services.	
	Outpatient rehabilitative services visit limits, if any, apply to Habilitative Services Covered Services.	
	Benefits are available to the same extent as benefits provided for other outpatient rehabilitative services.	
Pulmonary Rehabilitation		
Hospital/facility	90% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner		
Office	No Deductible required 100% of Allowed Benefit after \$50 Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Wellness services provided by the Group's Designated Wellness Services Provider	No Deductible required 100% of Allowed Benefit*	

* The Allowed Benefit is the Designated Wellness Services Provider's actual charge.

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

**TOTAL CARE AND COST IMPROVEMENT, PATIENT-CENTERED MEDICAL HOME,
ENHANCED MONITORING PROGRAM, EXPERT CONSULTATION PROGRAM,
SUBSTANCE USE DISORDER PROGRAM, HEALTH PROMOTION AND WELLNESS
PROGRAM, AND DISEASE MANAGEMENT ADDENDUM**

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	Health Promotion and Wellness Covered Services	This section describes the prevention and wellness services for members to help them avoid getting sick.
	Disease Management Covered Services	This section describes the disease management services for members to address and manage diseases they may have.
SECTION 3	SCHEDULE OF BENEFITS	

This Addendum is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. The effective date of coverage and termination date of coverage under this Addendum are the same as the effective date and termination date stated in the Group's Administrative Services Agreement for the benefits described herein.

The provisions of this Addendum do not apply to Members for whom Medicare is the primary carrier.

SECTION 1. DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage, for purposes of this Addendum, the underlined terms, below, when capitalized, have the following meaning:

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

Care Coordination Team, for purposes of the Patient-Centered Medical Home Program, means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, for purposes of the Patient-Centered Medical Home Program, means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses and includes case management through the Substance Use and Behavioral Health Program.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: Patient-Centered Medical Home Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Use and Behavioral Health Program, or other community-based programs outlined in this section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Enhanced Monitoring Program (EMP) means the CareFirst program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Expert Consultation Program (ECP) means the CareFirst Program for Members with a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

Health Promotion and Wellness Program means a coordinated program designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Health Care Provider, for purposes of the Patient-Centered Medical Home Program, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this section.

Primary Care Physician (PCP), for purposes of this Addendum, means health care practitioners in the following disciplines:

1. General practice medicine;
2. General internal medicine;
3. Family practice medicine;
4. Pediatric medicine; or
5. Geriatric medicine.

Qualifying Individual, for purposes of the Patient-Centered Medical Home Program, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Qualified Member means a Member who:

1. Is accepted by CareFirst into one or more of the TCCI Programs described in this section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.
2. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.
3. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.
4. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

Specialist, for purposes of this Addendum, means a licensed health care provider who is certified or trained in a specified field of medicine.

Substance Use Disorder means:

1. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or
2. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

Weight Loss Services means CareFirst approved services available to clinically obese Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion and Wellness Program.

Wellness Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Wellness Program.

SECTION 2. DESCRIPTION OF COVERED SERVICES

Benefits are available for:

A. TCCI Covered Services and Cost Sharing Waiver

1. Qualified Members are eligible for a waiver of certain cost sharing responsibility for benefits provided under this section when:
 - a. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or
 - b. At CareFirst's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in a CCM Program or a CCC Program.
2. Qualified Members participating in a CCM Program or a CCC Program as set forth in paragraph A.1.a., are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:
 - a. Assessment of Qualified Member/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;
 - b. Education of Qualified Member/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;
 - c. Assistance in navigating and coordinating health care services and understanding benefits;
 - d. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;
 - e. Assistance in arranging consultation(s) with Specialists;
 - f. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;
 - g. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.
 - h. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.
 - i. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

3. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under paragraph A.1.a., or, pursuant to CareFirst initiation under paragraph A.1.b., are eligible for benefits under following TCCI Program elements:
 - a. Comprehensive Medication Review (CMR). Benefits will be provided for a Pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.
 - b. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.
 - c. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.
 - d. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any Home Health Care visit limits stated in the Schedule of Benefits.
 - e. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.
 - f. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.
 - g. Substance Use and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and Substance Use Disorder services, including behavioral health treatment benefits.
4. Qualified Member Cost Sharing Responsibilities.
 - a. Any applicable cost-sharing responsibilities under this section (TCCI Covered Services and Cost Sharing Waiver) will be waived for (i) TCCI Program services provided by a Designated Provider, and (ii) in-network services provided to Qualified Members in an active plan of care.
 - b. Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits (ii) services provided in an inpatient institution or facility, or (iii) any services provided in a hospital.
 - c. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:
 - 1) If the Qualified Member has funded his/her HSA account during the calendar year, then the Qualified Member will be responsible for any associated costs for services under this section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

- 2) If the Qualified Member has not funded his/her HSA account during the calendar year, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in paragraph A.4.a.

5. Termination

- a. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this section will be terminated under the following circumstances:
 - 1) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner.
 - 2) When confirmed by the Qualified Member's treating physician or nurse practitioner if the TCCI Program(s) benefits are provided to Qualified Members not in an active plan of care.
 - 3) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.
 - 4) The Qualified Member's coverage under the Evidence of Coverage is terminated.
- b. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under paragraph A.5.a.3), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this section.
- c. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the effective date of the termination of the waiver.

B. PCMH Covered Services

Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.
2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.
3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;
4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

C. Enhanced Monitoring Program

Benefits for medical equipment and monitoring services will be provided to a Member, without an active plan of care, who qualifies under the EMP as determined by CareFirst.

D. Expert Consultation Program

Benefits for review of a Member's medical records by a team of specialists will be provided to a Member, without an active plan of care, who qualifies under the ECP as determined by CareFirst. The review of the Member's medical records will be done in accordance with the ECP.

E. Substance Use Disorder Program

Benefits will be provided for outpatient treatment of Substance Use Disorder, without an active plan of care, if:

1. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst;
2. The Member receives treatment from a recognized treatment center of excellence, as determined by CareFirst; and
3. Treatment is rendered through an intensive outpatient program (IOP) or an outpatient program at a recognized center of excellence as determined by CareFirst.

F. Health Promotion and Wellness Covered Services

1. Health Assessments are available for all adult Members.
2. Benefits are available for Biometric Screening of Members, as defined above.
3. Lifestyle Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.
 - b. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).

4. Other Wellness Program benefits are available, which may include tobacco-cessation, well-being challenges, and financial well-being improvement programs.
5. Weight Loss Services are available to clinically obese Members, as follows:
 - a. A clinically obese Member is a Member whose Body Measurement Index (BMI) score is greater than thirty (30).
 - b. A dedicated, CareFirst approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.
 - c. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

G. Disease Management Covered Services

1. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.
2. Disease Management Coaching Session services are available as follows:
 - a. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.
 - b. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

SECTION 3. SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies, or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment, as stated below.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Total Care and Cost Improvement Program	Limitations Home Health Care hospital/home health agency visit limit, if any, does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for TCCI Program or Patient-Centered Medical Home Program.	
TCCI program services provided pursuant to a plan of care	No Deductible required 100% of Allowed Benefit	No benefit
TCCI Program elements		
TCCI program services provided without a plan of care: Enhanced Monitoring Program, Expert Consultation Program, Substance Use Disorder Program	No Deductible required 100% of Allowed Benefit	No benefit
Patient-Centered Medical Home Program	Limitations Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst approved Health Care Provider who has elected to participate in the CareFirst Patient-Centered Medical Home Program.	
	No Deductible required 100% of Allowed Benefit	No benefit
Health Promotion and Wellness	Limitations Benefits for Weight Loss Services are only available to Members with a BMI score greater than thirty (30).	
Biometric Screening services	No Deductible required 100% of Allowed Benefit	No benefit
Wellness Coaching services		
Other Wellness Program services		
Weight Loss Programs		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Disease Management		
Disease Management services	No Deductible required 100% of Allowed Benefit	No benefit
Disease Management Coaching services	No Deductible required 100% of Allowed Benefit	No benefit

This Addendum is issued to be attached to the Evidence of Coverage.

CLAIMS PROCEDURES

Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group Health Plan has deemed itself subject to ERISA.

- A. DEFINITIONS**
- B. CLAIMS PROCEDURES**
- C. CLAIMS PROCEDURES COMPLIANCE**
- D. CLAIM FOR BENEFITS**
- E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)**
- F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**
- G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS**
- H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL**
- I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL**
- J. NOTICE**
- K. EXTERNAL REVIEW PROCESS**

A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,
2. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Claimant's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an InDependent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

Group Health Plan means an employee welfare benefit Plan within the meaning of section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of section 733(a) of the Act.

Health Care Professional means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

InDependent Review Organization (or IRO) means an entity that conducts inDependent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the claims administrator under this Group Contract.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Claimant's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeal of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Claimants.

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Rescissions are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.

C. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Claimant or authorized representative.

The above shall apply only in the case of a failure that:

- a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and
- b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA or under State law, as applicable.

D. CLAIM FOR BENEFITS

A Claim for Benefits is a request for a Plan benefit or benefits made by a Claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

1. In general. Except as provided in paragraph E.2, if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.
2. The Claimant shall be notified of the determination in accordance with the following, as appropriate.
 - a. Expedited Notification of benefit determinations involving urgent care. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
 - 1) Receipt of the specified information, or
 - 2) The end of the period afforded the Claimant to provide the specified additional information.

- b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
 - 1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
 - 2) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and Appeal shall be governed by paragraphs H.2.a, H.2.b, or H.2.c, herein as appropriate.
 - 3) Continued coverage will be provided pending the outcome of an Appeal.
- c. Other claims. In the case of a claim that is not an urgent care claim or a concurrent care decision the Claimant shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.
 - 1) Pre-Service Claims. In the case of a Pre-Service Claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein.

- 2) **Post-Service Claims.** In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.
 - d. **Calculating time periods.** For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.c above due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
3. **Deemed exhaustion of internal claims and Appeals processes.** If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:
 - a. The specific reason or reasons for the adverse determination;
 - b. Reference to the specific Plan provisions on which the determination is based;
 - c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
 - d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the Act following an Adverse Benefit Determination on review;
 - e. In the case of an Adverse Benefit Determination:
 - 1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
 - 2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
 - f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.
2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in paragraph E.2.a herein, provided that a written or electronic Notification in accordance with paragraph F.1 of this section is furnished to the Claimant not later than three (3) days after the oral Notification.

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

1. To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within 180 days of the Adverse Benefit Determination.
2.
 - a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
 - b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;
 - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;
 - b. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
 - c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - d. Health Care Professionals engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and
 - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and
 - b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.
5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided below and in paragraph H.2, a Claimant shall be Notified in accordance with paragraph I. herein of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.
2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.
 - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.
 - b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

- c. Post-service claims. In the case of a Post-Service Claim, except as provided below, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
- 3. Calculating time periods. For purposes of paragraph H. herein, the period of time within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph I.1 herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
- 4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs I.3, I.4, and I.5 herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

- 1. The specific reason or reasons for the adverse determination;
- 2. Reference to the specific Plan provisions on which the benefit determination is based;
- 3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;
- 4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and
- 5.
 - a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
 - b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and or your State insurance regulatory agency.

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan's Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:
 - a. The Plan or the Plan's Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
 - b. The Plan or the Plan's Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan's Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.
 - c. The Plan or the Plan's Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.
 - d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.
 - e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.
2. Form and manner of Notice.
 - a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.
 - b. Requirements
 - 1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;
 - 2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and

- 3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.
- c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.
2. If a Claimant is in need of assistance, they may contact the appropriate agency as follows:

Maryland Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(877) 261-8807
<http://www.oag.state.md.us/Consumer/HEAU.htm>
heau@oag.state.md.us

Additionally, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

3. Scope
 - a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.
 - b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:
 - 1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and

- 2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).
4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

- a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:
 - 1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - 2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);
 - 3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and
 - 4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

- c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

- 1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- 2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- 3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.
- 4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.

- 5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
- (a) The Claimant's medical records;
 - (b) The attending health care professional's recommendation;
 - (c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;
 - (d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- 6) The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.
- 7) The assigned IRO's decision Notice will contain:
- (a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;
 - (f) A statement that judicial review may be available to the Claimant; and
 - (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- 8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
- d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
- 5. Expedited External Review for self-insured Group Health Plans
 - a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:
 - 1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;
 - 2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
 - b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.

- c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.

- d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.

6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

APPENDIX A

The Prescription Drug Program

Enrollment in the Plan automatically includes coverage under the Prescription Drug Program. This program is administered separately from your medical benefits under the Plan by Express Scripts.

How the Prescription Drug Program Works

The Prescription Drug Program offers you the following two ways to fill prescriptions:

- At a local participating pharmacy;
- By home delivery (mail order), phone or online.

After two fills at a retail pharmacy for drugs you use on an ongoing basis, often referred to as maintenance drugs, you will be required to move your prescription to either the Express Scripts home delivery pharmacy or to a CVS or Walgreens pharmacy and fill the prescription as a 90-day prescription. After the courtesy fills are exhausted, you must pay the full cost of the prescription if you have not transitioned your maintenance medications to a Walgreens, CVS or the Express Scripts Pharmacy for a 90-day supply.

Regardless of your choice of pharmacy, you should present the ID card you received at enrollment along with your prescription. This may allow the pharmacy to help you file a claim for benefits.

Your cost varies depending on the type of drug and how you choose to fill your prescriptions.

Retail – Participating Pharmacy

If you fill your prescription at a retail pharmacy that is an Express Scripts participating pharmacy, the pharmacist will charge you the appropriate copayment for your prescription. That is the only amount you pay. (See "Amount of Copayment" below for details.)

Your copayment at a participating pharmacy for up to a 30-day supply is:

- \$10 for generic non-specialty drugs;
- \$20 for generic specialty drugs;
- \$30 for preferred brand non-specialty drugs; and
- \$60 for preferred brand specialty drugs.

Most specialty medications are required to be filled through Express Scripts Accredo specialty pharmacy. Only specialty medications that are considered emergency or stat specialty medications can be filled for the first fill at a retail pharmacy. After that, you must use the Plan's Express Scripts Accredo specialty pharmacy service.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

Medications that are filled for 90-days through a Walgreens or CVS pharmacy will follow the home delivery plan design that is outlined below.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

After two fills at a retail pharmacy for drugs you use on an ongoing basis, often referred to as maintenance drugs, you will be required to move your prescription to either the Express Scripts home delivery pharmacy or to a CVS or Walgreens pharmacy and fill the prescription as a 90-day prescription. After the courtesy fills are exhausted, you must pay the full cost of the prescription if you have not transitioned your maintenance medications to a Walgreens, CVS or the Express Scripts Pharmacy for a 90-day supply.

To find a participating retail pharmacy near you:

- Call Express Scripts toll-free at 1-800-211-8497;
- Access Express Scripts online at www.express-scripts.com; or
- Download the Express Scripts Mobile App.

Ask your local pharmacy if it is an Express Scripts participating pharmacy.

Retail – Nonparticipating Pharmacy

You must pay the full cost for your prescription when you use a nonparticipating pharmacy.

Express Scripts Home Delivery (Mail Order)

The Express Scripts mail service is a great way to fill prescriptions for medication you take on a long term or ongoing basis. You may receive up to a 90-day supply for one copayment. (See "Amount of Copayment or Coinsurance" below for details.)

Home delivery (mail order) may be your best option for prescription drugs that you take on a regular *basis for conditions such as asthma, high blood pressure, and high cholesterol*. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and sent to you in a plain, weather-resistant pouch for privacy and protection.

You may get up to a 90-day supply of your medications—which may mean fewer refills and fewer visits to your pharmacy, as well as lower costs. Once you begin using the home delivery, you can order refills online, by phone, through the mobile app or by mail.

You can choose between these easy options:

- Call Express Scripts at the toll-free number on the back of your member ID card and let Express Scripts do all the work. For most medications, Express Scripts will be able to contact your doctor for you and arrange for your first mail-order supply.

Visit **www.express-scripts.com/StartHD**. After logging in, select “Transfer your retail prescriptions” to get started. The Express Scripts Pharmacy will contact your doctor for you to obtain a 90-day prescription.

- Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate). Then, ask your doctor to electronically send the prescription to the Express Scripts Pharmacy.

To transfer any remaining maintenance medication refills from a retail pharmacy to home delivery, log in or register at **Express-Scripts.com** and look for “Transfer to Home Delivery” on the home page. Select the medications you’d like to transfer, click “Add to Cart” and checkout. Express Scripts does the rest.

Orders are usually processed 48 hours from when Express Scripts gets them. Your medicine should be delivered in about 8 days (10-14 days if it’s a new prescription). If Express Scripts needs to contact your doctor for information, delivery may take longer. You can check your order status by going online anytime. Your prescription drug will be mailed to your home at no charge for standard U.S. Postal Service delivery. You may request overnight delivery for an additional charge. You may also indicate if you want your medicine in a child-resistant or non-child-resistant bottle.

A pharmacist is available 24 hours a day to answer questions about your medicines.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

Your copayment for each prescription filled through home delivery is:

- \$20 for generic non-specialty drugs;
- \$20 for generic specialty drugs;
- \$60 for preferred brand non-specialty drugs; and
- \$60 for preferred brand specialty drugs.

Home delivery of a 90-day supply of insulin, syringes, and diabetic supplies, will be covered at the same rate as a retail 30-day supply.

Non-preferred brand name drugs are not covered, except as provided in "How Prescription Drugs Are Classified," below.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Amount of Copayment

The amount of your copayment or coinsurance depends on where your prescription is filled, whether it is filled with a generic or brand drug, and whether it is for a specialty or non-specialty drug.

Type of Drug	In-Network Retail	Walgreens/CVS/ESI Mail Order	Out-of-Network
Generic Non-Specialty	\$10 copay (30-day supply)	\$20 copay (90-day supply)	not covered
Generic Specialty	\$20 copay (30-day supply) (1 fill only)	\$20 copay (30-day supply)	not covered
Preferred Brand Non-Specialty	\$30 copay (30-day supply)	\$60 copay (90-day supply)	not covered
Preferred Brand Specialty	\$60 copay (30-day supply) (1 fill only)	\$60 copay (30-day supply)	not covered
Insulin, Syringes, and Diabetic Supplies	Retail copay applies (30-day supply)	Retail copay applies (90-day supply)	not covered

Your medical and prescription drug claims are combined when determining whether you have met the In-Network Out-of-Pocket Maximum. Once the In-Network Out-of-Pocket maximum amount is met, the Plan will pay 100% of your allowable medical and prescription drug costs.

In-Network Out-of-Pocket Maximum:

- \$5,000 Single (Employee only)
- \$10,000 Family (Employee+Spouse, Employee+Child, Family)

How Prescription Drugs Are Classified

A **generic drug** is a medication chemically equivalent to a brand name drug on which the patent has expired. Generic versions of brand name drugs contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs. See the section "Generics Preferred" for details about how the Plan pays benefits for generic drugs.

A **preferred brand-name drug** is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. A preferred brand drug is a drug that is included on the Plan's drug formulary list as a prescription drug product preferred by the Prescription Drug Program for dispensing. Preferred brand name drugs do not have a generic equivalent. These medicines have been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and have been selected by Express Scripts to be included in the formulary based on their proven clinical and cost effectiveness.

Non-preferred brand-name drugs are not included on the Plan's drug formulary list, and generally they are not covered by the Prescription Drug Program. These drugs usually have an alternative therapeutically-equivalent drug available. In the rare event that your medical condition requires a non-preferred drug, and if you have tried and failed with two similar drugs on the formulary list, your doctor may contact Express Scripts to ask to have a non-preferred drug authorized for you. If your request is approved, benefits for the non-preferred drug will be the same as they would be for the preferred brand.

The Prescription Drug Program has a "generics preferred policy" to encourage the use of generic drugs. There are some brand name drugs for which generic equivalents are available. If you fill a prescription for a brand name medication that has a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand name drug and the generic drug (the ancillary charge), *in addition* to the generic copayment.

Drugs Requiring Prior Authorization

Some drugs require prior authorization. This means that Express Scripts will need to make sure these prescriptions meet the Plan's conditions for coverage. (You can contact Express Scripts for a current list of drugs that require prior authorization.) If a drug you take requires prior authorization, your physician will need to contact Express Scripts for a clinical review. If your prescription is authorized, you will pay your copay. If the prescription is not approved for coverage, and you and your physician decide that you should still take the prescribed drug that was not authorized, you will pay the full cost of the medication.

To determine if your medication requires prior authorization, **your physician** (not you) should call the Express Scripts' prior authorization line at 1-800-753-2851. The best way to avoid inconvenience is to have your physician contact the Express Scripts prior authorization department either electronically or by calling the prior authorization line before you go to the pharmacy or send for your prescription by mail. The prior authorization line is not for patient use. You cannot obtain prior authorization by calling this line yourself.

Dispensing Limits and Other Limits

To promote safety and appropriate and cost-effective use of prescription drugs, the Prescription Drug Program includes a "drug quantity management" feature. For certain prescription drugs, it places a limit on the quantity that can be dispensed at one time. Quantity dispensing limits are based on:

- The manufacturer's recommended dosage and duration of therapy;
- Common usage for episodic or intermittent treatment;
- FDA-approved recommendations and/or clinical studies; and
- Guidelines of the Plan.

In addition to the above limits, the Prescription Drug Program limits the number of days for which a prescription can be filled. For each prescription filled for a non-specialty drug, you can obtain a supply of up to 90 days. For each prescription filled for a specialty drug, you can obtain a supply of up to 30 days.

The Prescription Drug Program provides benefits for fertility drugs, **up to a lifetime maximum benefit of \$10,000**. Benefits are not otherwise available for the treatment of Infertility.

Step Therapy Program

"Step therapy" manages appropriate use of first-line, clinically effective, lower-cost drugs before using a more expensive second-line drug. Step therapy requires patients to receive a trial of one or more first-line drugs before prescriptions are covered for second-line drugs when medically appropriate.

To promote the use of cost-effective first-line therapy, the Prescription Drug Program applies step therapy for certain drug categories, including but not limited to the following:

- Arthritis and pain medicines (COX-2s) such as Celebrex;
- Blood pressure or heart medicines (angiotensin receptor antagonists) such as Diovan and Benicar;
- Asthma, allergic rhinitis, and chronic bronchitis medicines such as Aerospa; and
- High cholesterol medicines (HMGs) such as Crestor and Vytorin.

A physician can override the step therapy program **when appropriate for medical reasons** by submitting a prior authorization request to Express Scripts by calling 1-800-753-2851.

Management of Pain Medications called Opioids

Express Scripts proactively educates patients new to pain medications called opioids and related therapies via member-friendly outreach outlining risks and safety tips for taking their prescription, and proper disposal of unused medications. To maximize patient safety by minimizing early opioid and related therapies exposure, Express Scripts requires prior authorization and limits on the quantity of opioid medications that can be dispensed at one time. These requirements do not apply if a member has a history of cancer or palliative care.

- Days' Supply Limit of a First Fill of a Short Acting Opioid: To prevent excess opioid medications, a days' supply limit is placed on the first fill of a short acting opioid for new opioid users.
- Prior Authorization on all Long Acting Opioids: To ensure that patients are appropriately started on long-acting opioids, Express Scripts will implement a Prior Authorization on all long-acting opioids if the member has not had a prior fill for an opioid.
- Morphine Equivalent Dose (MED) based quantity limit: As not all opioids are the same, this quantity limit manages the potential over-utilization of opioid medications by tracking the Morphine Equivalent Dose (MED) for each opioid dispensed. This cumulative quantity limit sums from each active prescription the result of morphine equivalent dose calculations – a conversion factor of the pain relief value of an opioid medication to the comparable pain relief provided by morphine - and compares it to a pre-defined threshold which requires additional review and prior authorization, if exceeded.
- Quantity Limit on Fentanyl Patches: Fentanyl products are generally only approved for treatment of breakthrough cancer pain and are considered long-acting opioids. To ensure continued patient safety and alignment with FDA recommendations, Express Scripts has placed quantity limits on the number of fentanyl patches that can be dispensed at one time.

- Prior Authorization on Transmucosal Immediate Release Fentanyl (TIRF) Products: TIRF products are approved only for treatment of breakthrough cancer pain. To support FDA guidelines, Express Scripts has implemented a prior authorization requirement on these products to ensure an additional prescriber evaluation is completed prior to dispensing.

Express Scripts Specialty Pharmacy

Accredo is Express Scripts' full-service specialty pharmacy. It serves a wide range of patients, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, and post-transplant needs.

Most specialty medications are required to be filled through Express Scripts Accredo specialty pharmacy. Only specialty medications that are considered emergency or stat specialty medications can be filled for the first fill at a retail pharmacy. After that, you must use the Plan's Express Scripts Accredo specialty pharmacy service.

Accredo offers a complete range of services and specialty drugs, many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medicine.

To begin receiving your specialty drugs through Accredo, call them toll-free at 1-800-803-2523.

Accredo services include:

- Patient counseling — convenient access to pharmacists and nurses who are specialty medicine experts;
- Patient education — education material;
- Convenient delivery — coordinated delivery to your home, your doctor's office, or other approved location;
- Refill reminders; and
- Language assistance — interpreting services for non-English-speaking patients.

Prescription Drug Program Exclusions

The following are not covered under the Prescription Drug Program:

- Drugs and medicines that ordinarily can be obtained without a prescription (i.e. over-the-counter medications);
- Erectile dysfunction drugs (e.g., Viagra);
- Anabolic steroids (e.g., Winstrol, Anadrol-50, Oxandrin, Deca-Durabolin);
- Appetite suppressants and other weight loss products;
- Durable medical equipment (except for nebulizer/supplies, breathing devices-peak meters and breathing supplies);

- Injectable serums, vaccines or allergens;
- Legend hair growth products (e.g., Propecia);
- Legend hair removal products (e.g., Vaniqa);
- Legend vitamins (except prenatal vitamins, b-12 injection, vitamins with fluoride);
- Prescriptions that exceed the 90-day limit;
- All proton-pump inhibitors (PPI) products (e.g., Prilosec, Nexium, Prevacid) that treat conditions such as heartburn;
- Not more than 1 replacement prescription for vacation override or lost or stolen prescription; and
- Any drug or chemical not approved by the Food and Drug Administration in the dosage prescribed, for the reason prescribed, on in the form prescribed. This includes, but it not limited to, non-FDA approved compounded drugs.

Note that if you participate in the HealthCare Flexible Spending Account, the portion you pay for over-the-counter medications may be eligible for reimbursement through your health care FSA if you submit a written prescription from your doctor for the medication.

For certain other prescription drug exclusions, please consult the section of this Booklet entitled "Expenses Not Covered."

Filing a Prescription Drug Claim

You do not need to file a claim if you use a participating pharmacy. You only need to complete a special order envelope when you use home delivery. On a refill, it is even easier; you can just call or go online and provide your credit card number.

If you use a nonparticipating pharmacy, you need to pay the full cost for the prescription and file a claim for reimbursement.

Information When You Need It at www.express-scripts.com

Go online to www.express-scripts.com for 24-hour access to information regarding the Prescription Drug Program. Use this website to:

- Find out about your copayment amounts;
- Verify coverage for eligible dependents;
- View or print a list of drugs included in the Plan's formulary;
- Locate participating retail pharmacies near you;
- Review your 12-month prescription history;
- Order refills; and

- Check the status of your mail order prescription.

Register now to access www.express-scripts.com. Once you are registered, you will have the information you need.

The Express Scripts Mobile App

The Express Scripts mobile application (app) helps members make better decisions for healthier outcomes – anytime, anywhere. The app has earned a consistent 4.5 star rating for all versions beginning in 2015.

The app is compatible with most iPhone®, iPad®, Android™, Windows Phone®, Amazon and BlackBerry® mobile devices. To download the Express Scripts mobile app, members should search for “**Express Scripts**” in their mobile device’s app store and download it for free.

Note: Features available on the mobile app are based on the member’s plan design and the Perdue’s profile set-up.

Members who are not already registered via express-scripts.com will need to create a username and password by registering on the app before they can have a fully personalized mobile experience. The same username and password can be used to access express-scripts.com.

Members who have **Apple’s touch ID authentication** on their iPhone or iPad devices can enable it to login to their Express Scripts account on the mobile app, if desired.

Members can navigate to the mobile website from their internet browser on their mobile device. The mobile website has the same features and functionality as the Express Scripts mobile app.



PERDUE TUITION REIMBURSEMENT PROGRAM

The Perdue Tuition Reimbursement Program (“Program”) is provided for all non-Union Associates of Perdue Farms Inc., Perdue AgriBusiness LLC, and Perdue Foods LLC (collectively, “Perdue” or the “Company”).

The Program may be amended, revised, or nullified by Perdue at any time, with or without notice. This Program is offered to Perdue Associates as a benefit of employment. Perdue has the sole discretion to interpret the meaning of the provisions of the Program and to grant or deny benefits, whether with respect to the terms of the Program or for business necessity. Perdue reserves the right to suspend the Program contingent upon available budget and/or economic conditions.

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Associate Eligibility Criteria

Regular, full-time, non-union Associates are eligible to participate in the Program. A regular, full-time Associate is one who is regularly scheduled to work 40 hours or more each week. To qualify for Program benefits, Associates must have been actively employed by Perdue for six continuous months prior to beginning a course of study and, where applicable, be at “*Achieves*” performance level or above as per the Performance and Development Plan Process.

Associates may submit a ***TA-1 Plan Entry Approval Form*** prior to completing their six months of service. Associates may not begin the actual covered course work, however, until having completed the six-month period of service.

Associates who are eligible for tuition reimbursement from a non-Company source, such as the GI Bill or other grants, that would otherwise cover the desired course(s) in full are not eligible for benefits under this Program. Where the non-Company source does not cover the total cost of a desired course, Perdue will supplement the cost difference in accordance with the terms set out below.

Tuition Assistance Eligibility Criteria

Approval for any qualified course of study will be given only if it is considered by the Company to meet the following criteria:

- (1) It is deemed a requisite for the job presently held or a future job the Associate wishes to hold within that Associate’s line of progression; and/or

- (2) It will help prepare the Associate to qualify for advancement and opportunities within Perdue's business that are in line with the Associate's abilities and interests and the needs of Perdue.

The prerequisites for approval under this Program are listed below:

- (1) Perdue will provide tuition reimbursement for any Associate desiring a high school equivalency diploma.
- (2) Applications will be accepted from *hourly* Associates and/or Associates whose positions are in Pay Grade H or below for an Associate's Degree or Bachelor's Degree course of study/program. Tuition assistance will be provided up to a maximum of \$5,250 per year.
- (3) Applications will be accepted from *salaried* Associates whose positions are in Pay Grade 1 or above for an Associate's, Bachelor's, or Master's Degree course of study/program. Tuition assistance will be provided up to a maximum of \$5,250 per year.
- (4) Applications will be accepted from *salaried* Associates whose positions are at Director Level in Pay Grade 12 or above for a Doctorate Degree course of study/program. Tuition assistance will be provided up to a maximum of \$5,250 per year.
- (5) For Associates approved for accelerated EMBA programs or other relevant Master's programs in conjunction with the Talent Management Process, tuition reimbursement will be provided up to a maximum of \$5,250 per year.
- (6) Associates who have been accepted into the Program, but have not submitted a reimbursement request for 6 months or longer, will be considered inactive and will need to reapply using the **TA-1 Plan Entry Approval Form** in order to continue receiving tuition reimbursement benefits.

Acceptable Institutions & Study Programs

Approvals will only be given to courses of study/degree programs offered by accredited educational institutions. In general, all accredited universities, two and four-year colleges, and public vocational schools are approved institutions, as follows:

2-Year Undergraduate Degrees – Programs that require a minimum number of academic courses/hours/credits (generally 60 credits) and lead to an Associate's Degree.

4-Year Undergraduate Degrees – Programs that require a minimum number of academic courses/hours/credits (generally 120 credits) and lead to a Bachelor's Degree.

Graduate Degrees – Programs that require a minimum number of academic courses/hours/credits (generally 35-40 credits) and lead to a Master's Degree.

There may be instances where a specific course of study, while through an accredited institution, may not be an accredited program. Perdue reserves the right to assess whether reimbursement shall be provided under such circumstances.

Perdue will consider for approval a program that is traditional or accelerated and in-class/on-campus, on-line, home study, or correspondence courses. Home study or correspondence courses may qualify for consideration, provided they are taken through accredited educational institutions and are governed by the same policies and procedures of this Plan.

Course Attendance & Course Work Completion

Course attendance and course work is to be completed outside of an Associate's established work schedule. Where appropriate, Perdue may consider approving course work occurring during scheduled work hours, where the following criteria are met:

- (1) The Associate has at least two years continuous employment with Perdue and is performing at acceptable work standards; and
- (2) The Associate's Supervisor/Manager, in conjunction with the Functional/Business Group Leader, approves the alternate schedule.

Tuition Assistance Benefits

Associates are entitled only to reimbursement of costs, which means they are responsible for all initial payments to the school or other educational institution. **Tuition reimbursement covers only the cost of tuition and course materials and books.** It does not include any other expenses, such as those incurred in connection with financing, travel, food, or lodging.

Perdue will offer tuition reimbursement based on the grade attained on the completion of the approved course:

<u>Grade</u>	<u>Reimbursement Percentage</u>
A's & B's	100%
C's	80%
D's & below	0%
Pass/Fail	Pass 100%/Fail 0%

Associates will receive the appropriate reimbursement upon completion of each approved course up to the total, aggregate, annual calendar reimbursement maximum of \$5,250, provided that the **TA-2 Request for Reimbursement** form is completed and submitted within 30 days of receiving the official grade report and applicable tuition/book receipts.

Approval Request Procedures

An Associate's intent to participate in this Program and pursue a course of study/degree program must be submitted to and approved by Learning and Development prior to course(s) start. Associates should complete a **TA-1 Plan Entry Approval Request** form, which must first be approved by the Associate's manager and Human Resources Manager or Business Partner before being submitted to Learning and Development.

Termination of Employment/Repayment Obligation

If an Associate chooses to terminate his/her employment with the Company for any reason, or if the Company discharges the Associate for any reason other than a reduction in force, prior to the end of one full calendar year following the last reimbursement date, the Associate will be obligated to repay to Perdue the total of all reimbursements paid by Perdue for the 12-months period leading up to the termination of employment. Any pending tuition reimbursement requests shall automatically be denied.

Acceptance of tuition reimbursements by the Associate shall be deemed an acceptance of and agreement by the Associate to the refund obligation set forth herein. The Associate hereby agrees to allow Perdue to withhold wages due in repayment of any obligation under this section in accordance with applicable law.

PERDUE SHORT TERM DISABILITY PLAN
(A Component of the Perdue Farms Inc. Welfare Benefit Plan)

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

Restated Effective January 1, 2014

This document contains a summary of the benefits available under the Perdue Short Term Disability Plan. If you have any difficulty understanding any part of this document, you should contact your Human Resources Department for assistance.

El Manual contiene un sumario en Inglés de sus derechos y beneficios bajo el plan. Si usted tiene alguna dificultad en entender cualquier parte del Manual, usted deberá contactar a su Departamento de Recursos Humanos para que lo asista.

PERDUE SHORT TERM DISABILITY PLAN

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PERDUE SHORT TERM DISABILITY PLAN

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

The PERDUE SHORT TERM DISABILITY PLAN is hereby amended and restated, effective for all purposes as of January 1, 2014.

ARTICLE I. INTRODUCTION

- 1.1 Purpose of Plan. The purpose of this Plan is to provide Participants with short-term disability benefits.
- 1.2 Plan Document and Summary Plan Description. This document, together with its Exhibits, and together with the applicable portions of the Perdue Farms Inc. Welfare Benefit Plan, constitutes the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

ARTICLE II. DEFINITIONS AND CONSTRUCTION

- 2.1 Definitions. The following definitions shall apply to this Plan. However, in the event of a conflict between a definition below and a definition in an Exhibit to this document, the definition in the Exhibit shall apply.
 - a. “Benefits” means the services provided or amounts paid to or on behalf of Participants under the Plan.
 - b. “Company” means Perdue Farms Inc. and any successor entity.
 - c. “Employee” means an individual who the Employer classifies and treats as an employee (not as an independent contractor) for payroll purposes, regardless of whether the individual is subsequently reclassified as an employee of the Employer in a court order, in a settlement of an administrative or judicial proceeding, or in a determination by the Internal Revenue Service, the Department of the Treasury, or the Department of Labor.
 - d. “Employer” means Perdue Farms Inc., or any affiliate or subsidiary corporation that adopts this Plan with the consent of the Company.
 - e. “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.
 - f. “Exhibit” means an exhibit to this document. If there are multiple exhibits to this document, then unless the context requires otherwise, Exhibit means the exhibit with the most recent effective date. All Exhibits are hereby incorporated into this document.

PERDUE SHORT TERM DISABILITY PLAN

- g. "Participant" means an Employee who is eligible to participate and begins participating in the Plan, all in accordance with Article III.
 - h. "Plan" means this Perdue Short Term Disability Plan.
 - i. "Plan Administrator" means the Perdue Benefits Committee as the Plan Administrator, unless and until the Company designates a new Plan Administrator as described in Article V.
 - j. "Plan Year" means January 1 to December 31.
- 2.2 Construction. As used in this Plan, the masculine gender includes the feminine, and the singular may include the plural, unless the context clearly indicates to the contrary.

ARTICLE III. ELIGIBILITY, ENROLLMENT, & PARTICIPATION

- 3.1 Eligibility. An Employee becomes eligible to participate in this Plan as described in the Exhibit.
- 3.2 Enrollment. An eligible Employee becomes a Participant in this Plan by submitting completed versions of such enrollment materials as may be required by the Plan Administrator, within such time frames as may be required of the Plan Administrator.
- 3.3 Cessation of Participation. An individual's Participation in this Plan ceases on the earliest of the following:
- a. The Participant elects to drop coverage during an annual enrollment period or during any other period when such a change is permitted by the Plan Administrator.
 - b. The Participant fails to make the required contribution.
 - c. The Participant ceases to be an eligible Employee.
 - d. The Plan is terminated in accordance with Article VII.

ARTICLE IV. BENEFITS

- 4.1 Benefits. The Benefits under this Plan shall be as described in the Exhibit.
- 4.2 Termination of Benefits. Benefits shall terminate when participation terminates, as described in Section 3.3, or if earlier, as described in the Exhibit.

PERDUE SHORT TERM DISABILITY PLAN

ARTICLE V. ADMINISTRATION OF PLAN

- 5.1 Funding. The Benefits may be funded by an insurance policy, by the Employer's general assets, by Employee contributions, or by some combination of these. The amount of Employee contributions, if any, shall be established by the Employer. The Employer reserves the right to modify the amount of the Employee contributions, as the Employer in its absolute discretion shall determine from time to time.
- 5.2 Limitation of Rights. Nothing in this document requires the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant. No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made. Nothing in this Plan shall give any Employee any right to continued employment.
- 5.3 Power of Appointment. The Company has the power to appoint the Named Fiduciary and the Plan Administrator. The Company has appointed the Perdue Benefits Committee as the Plan Administrator and Named Fiduciary.
- 5.4 Plan Administrator. The Company has the power to appoint an individual or a committee to serve as the Plan Administrator. An individual appointed by the Company may resign by providing written notice to the Company. A committee appointed by the Company may act by a majority of its members at the time in office, either by vote at a meeting or in writing without a meeting. Such a committee may authorize any one or more of its members to execute any document or documents on behalf of the Plan Administrator.
- 5.5 Powers and Duties of the Plan Administrator. Except as otherwise provided in or delegated under the Perdue Farms Inc. Welfare Benefit Plan, the Plan Administrator shall have full power to administer the Plan, in accordance with its terms, for the exclusive benefit of Participants. For this purpose, the Plan Administrator's full and discretionary powers include, but are not limited to, the following:
- a. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable law;
 - b. To consider and decide claims and appeals filed under the Plan;
 - c. To determine the eligibility, participation, status, and rights of all individuals under the Plan;
 - d. To construe or interpret any and all terms of the Plan;
 - e. To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and

PERDUE SHORT TERM DISABILITY PLAN

- f. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation or designation shall be in writing.

All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

- 5.6 Indemnification of Plan Administrator. The Company agrees to indemnify and to defend, to the fullest extent permitted by law, any member (or former member) of a committee appointed by the Company to serve as the Plan Administrator, or any Employee (or former Employee) appointed by the Company to serve as the Plan Administrator, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE VI. CLAIMS PROCEDURES

- 6.1 Definitions. For purposes of this Article:

- a. "Claim" means a written request for Benefits under this Plan.
- b. "Claimant" means any person who submits a Claim, including any authorized representative who submits a Claim on another's behalf.

- 6.2 Claims Administrator. The Plan Administrator may serve as the Claims Administrator. Alternatively, the Plan Administrator may designate some or all of its duties under this Article to a separate Claims Administrator.

- 6.3 Initial Claim.

- a. Submitting an Initial Claim. In order to receive Benefits under the Plan a Claimant must submit a Claim according to the procedures set forth in the Exhibit. If there are no procedures set forth in the Exhibit, Claims should be submitted to the Claims Administrator.
- b. Timing of Initial Claim. A Claim must be filed no later than one year after the date of Disability.
- c. Claimant's Failure to Follow Procedures. Claimant's failure to follow the claims procedures shall be treated as if the Claim had not been filed. The Claims Administrator shall not be obligated to notify the Claimant of such failures.
- d. Approval of Initial Claim. If a Claim is approved, the Claims Administrator will provide the Claimant with written or electronic notice of such approval.

PERDUE SHORT TERM DISABILITY PLAN

- e. Notice of Denial of Initial Claim. If a Claim is denied (in whole or in part), the Claims Administrator will provide the Claimant with written or electronic notification of such denial. The notice of denial of the Claim will include:
- i. The specific reason that the Claim was denied;
 - ii. A reference to the specific provisions of the Plan on which the denial was based;
 - iii. A description of any additional material or information necessary to perfect the Claim and an explanation of why this material or information is necessary;
 - iv. If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;
 - v. If the denial of a Claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and
 - vi. A description of the appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA § 502(a) if the Claim is denied on appeal;
- f. Timing of Claims Decision. The notice required by this Section will be provided within 45 days after receipt of the Claim by the Claims Administrator, unless an Extension of Time is required and provided consistent with Section 6.5.

6.4 Appeals.

- a. Filing an Appeal. In the event that a Claim is denied (in whole or in part), the Claimant may appeal the denial by providing a written notice of appeal to the Claims Administrator within 180 days after the Claimant receives the notice of denial of the Claim. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, records, and other information relating to the Claim. The Claimant is entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial Claim (whether a document is relevant will be determined pursuant to 29 C.F.R. § 2560.503-1(m)(8)).

PERDUE SHORT TERM DISABILITY PLAN

- b. General Appeal Procedure. The Claims Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding upon both parties. In deciding the appeal:
- i. No deference will be given to the decision denying the initial Claim.
 - ii. The appeal will be decided by an individual who did not decide the initial Claim and who is not a subordinate of anyone who decided the initial Claim.
 - iii. The individual deciding the appeal will review and consider all information submitted by the Claimant, without regard to whether the information was submitted or considered in conjunction with the initial Claim.
 - iv. If the appeal is based, in whole or in part, on a medical judgment, the individual deciding the appeal will consult with a health care professional who has appropriate training and experience in the relevant field; the health care professional will not be an individual who participated in the denial of the initial Claim and will not be the subordinate of any such individual.
 - v. If the Plan Administrator obtained advice from any medical or vocational experts in conjunction with the initial Claim, such experts will be identified to the Claimant (this identification must occur even if the Plan Administrator did not rely on the advice obtained).
- c. Notice of Decision on Appeal. The appeal decision will be provided in written or electronic form to the Claimant. If the appeal decision is adverse to the Claimant, the written decision will include the following:
- i. The specific reason or reasons for the appeal decision;
 - ii. Reference to the specific provisions of the Plan on which the appeal decision is based;
 - iii. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim (whether a document, record, or other information is relevant to a Claim will be determined by reference to 29 C.F.R. § 2560.503-1(m)(8));
 - iv. A statement describing any voluntary appeal procedures and the Claimant's right to obtain the information about such procedures;
 - v. If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding a Medical Claim or Disability Claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such

PERDUE SHORT TERM DISABILITY PLAN

rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

- vi. If the denial of a Medical Claim or Disability Claim is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request;
 - vii. A statement of the Claimant's right to bring an action under ERISA § 502(a); and
 - viii. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- d. Timing of Notice of Decision on Appeal. The Plan Administrator will render a decision on appeal within 45 days after receipt of the appeal by the Plan Administrator, unless an Extension of Time is required and provided consistent with Section 6.5.

6.5 Extensions of Time.

- a. Notice of Extension. If the Claims Administrator requires an extension of time to review a Claim or an appeal, the Claims Administrator will provide the Claimant with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include:
 - i. An explanation of the circumstances requiring the extension, which circumstances must be matters beyond the control of the Claims Administrator;
 - ii. The date by which the Claims Administrator expects to render a decision;
 - iii. The standard on which the Claimant's entitlement to a benefit is based; and
 - iv. The unresolved issues that prevent a decision on the Claim or on appeal, and the information needed to resolve those issues. In the event such information is needed, the Claimant will have at least 45 days in which to provide the specified information. In addition, the time for determining an initial Claim will be tolled from the date on which the notice of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
- b. Length of Extensions. The Claims Administrator's ability to extend the time for rendering a decision is subject to the following limitations:

PERDUE SHORT TERM DISABILITY PLAN

- i. For an Initial Claim, no more than two extensions of 30 days each.
- ii. For an Appeal, no more than one extension of 45 days.

ARTICLE VII. AMENDMENT AND TERMINATION

- 7.1 Amendment. This Plan may be amended at any time and from time to time by a written instrument approved by the Company and executed by a duly authorized officer of the Company.
- 7.2 Termination. This Plan is established with the intention of being maintained for an indefinite period of time. Nevertheless, the Company expressly reserves the right to discontinue or terminate this Plan. After the Company has discontinued or terminated the Plan, no Employee, Dependent or Beneficiary shall have or attain any vested right, contractual or otherwise, to any further contributions to or benefits from the Plan.

ARTICLE VIII. MISCELLANEOUS

- 8.1 Employment Not Guaranteed. The Employer may terminate the employment of any Employee as freely and with the same effect as if this Plan were not in existence. Participation in this Plan shall not constitute an express or implied contract of employment between the Employer and the Employee.
- 8.2 No Guarantee of Tax Consequences. Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant will be excludable from the gross income of such person for federal or state income tax purposes or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether any payment under this Plan is excludable from gross income for federal and state income tax purposes and to take appropriate action if there is reason to believe that any payment or amount withheld is not excludable. Neither the Employer nor the Plan Administrator is liable for any taxes or penalties owed by any Participant with respect to such amounts.
- 8.3 Additional Taxes or Penalties. If there are any taxes or penalties payable by the Employer on behalf of any Employee, such taxes or penalties shall be payable by the Employee to the Employer to the extent such taxes would have been originally payable by the Employee had this Plan not been in existence.
- 8.4 No Rights Against Employer. The establishment of the Plan, any modification of the Plan, or any distributions from the Plan shall not be construed as giving to any current or former Employee under the Plan any legal or equitable rights against the Employer, its shareholders, directors or officers, as such, or as giving any person the right to be retained in the employ of the Employer.

PERDUE SHORT TERM DISABILITY PLAN

- 8.5 Payments Due Minors or Incapacitated Persons. If any person entitled to a payment under this Plan is a minor, or if the Plan Administrator determines that any such person is incapacitated by reason of physical or mental disability, whether or not legally adjudicated as incompetent, the Plan Administrator shall have the power to cause the payment to be made to another for his benefit, without responsibility of the Plan Administrator, the Employer, the Company, or any other person or entity to see to the application of such payment. Payments made pursuant to this power shall operate as a complete discharge of the Plan Administrator, the Employer, the Company, and the Plan.
- 8.6 Governing Law. This Plan is established in the State of Maryland. To the extent federal law does not apply, this Plan shall be construed in accordance with and governed by the laws of the State of Maryland.
- 8.7 Alienation. No Benefits under this Plan may be subject to anticipation, garnishment, attachment, execution or levy of any kind, or be liable for any Participant's debts or obligations.

ARTICLE IX. ERISA INFORMATION

- 9.1 Plan Name. The name of the Plan is Perdue Short Term Disability Plan.
- 9.2 Plan Sponsor's Name and Address. The name and address of the Plan Sponsor are Perdue Farms Inc., P.O. Box 1537, Salisbury, MD 21802-1537.
- 9.3 Plan Sponsor's Employer Identification Number (EIN). The Company's employer identification number is 52-0888853.
- 9.4 Plan Number. This Plan is a component of the Perdue Farms Inc. Welfare Benefit Plan. The identification number for the Perdue Farms Inc. Welfare Benefit Plan is 502. This Plan does not have a separate identification number.
- 9.5 Type of Plan. The Plan is an employee welfare benefit plan, which provides the welfare benefits described on the Exhibit.
- 9.6 Type of Administration. The administration of the Plan is performed by the Employer and by any additional service providers or insurers listed on the Exhibit.
- 9.7 Plan Administrator Information. The name, business address, and business phone number of the Plan Administrator are Perdue Benefits Committee, P.O. Box 1537, Salisbury, MD 21802-1537.
- 9.8 Agent for Service of Legal Process. Service of legal process may be made upon the Plan Administrator.
- 9.9 Trustee. The Plan does not use a trust and therefore does not have any trustees.

PERDUE SHORT TERM DISABILITY PLAN

- 9.10 Exclusive Benefit and Legal Enforceability. This Plan is maintained for the exclusive benefit of Participants and Beneficiaries. The Employer intends that the terms of this Plan, including those relating to coverage and benefits, are legally enforceable.
- 9.11 Eligibility for Participation and Benefits. The Plan's requirements for participation and benefits are set forth in Section 3.1 and in the Exhibit.
- 9.12 Summary of Benefits. The benefits provided under this Plan are summarized in the Exhibit.
- 9.13 Loss of Eligibility and Benefits. The circumstances which could result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery of benefits, are set forth in Article III, Article IV, and the Exhibit.
- 9.14 Plan Funding. The Benefits under this Plan are funded as described herein and in the Exhibit.
- 9.15 Funding Medium. The following funding medium is used for the accumulation of assets under the Plan: None.
- 9.16 Plan Year. The plan year January 1 to December 31.
- 9.17 Claims Procedures. The claims procedures for are set forth in Article VI and the Exhibit.
- 9.18 Further Information. An Employee may obtain further information about the Plan by contacting the Plan Administrator.
- 9.19 Inspection of Plan. The Employer will make the Plan and all related documents incorporated herein by reference available for inspection at its offices at no cost upon reasonable notice.
- 9.20 Copy of Plan. Upon reasonable notice and written request a copy of this Plan may be obtained from the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.
- 9.21 Statement of ERISA Rights. As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual

PERDUE SHORT TERM DISABILITY PLAN

report (Form 5500 Series), if any, and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

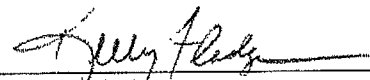
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PERDUE SHORT TERM DISABILITY PLAN

IN WITNESS WHEREOF, this Plan has been duly executed by the following authorized individual.

A handwritten signature in cursive script, appearing to read "Kelly Fladger", is written over a horizontal line.

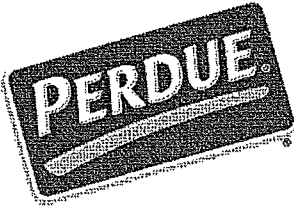
Kelly Fladger
Vice President, Human Resources

PERDUE SHORT TERM DISABILITY PLAN

LIST OF EXHIBITS

Exhibit A	Perdue Human Resources Policies and Procedures Short Term Disability Policy (Policy No. 218) Revision Date 1/1/2012
Exhibit B	Perdue STD 2015 Approved Changes All Changes Effective 1/1/2015

EXHIBIT A

	HUMAN RESOURCES POLICIES AND PROCEDURES	
	SUBJECT: Short Term Disability (STD)	EFFECTIVE DATE: 1/1/2009 REVISION DATE: 1/1/2012
	POLICY NO. 218	Page 1 of 10

This is a total policy revision of former policy 501 (STD).

This Policy covers all individuals employed by Perdue Agribusiness, Inc., Perdue Food Products, Inc., and/or Perdue Business Services, Inc. (excluding Milford union live haul drivers)

I. SUMMARY

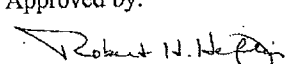
Perdue Agribusiness, Inc., Perdue Food Products, Inc., and/or Perdue Business Services, Inc., (the "Company") recognizes the need for income protection in the event of a short term or temporary disability where the injury or illness is not work related. This policy establishes the conditions under which Short-Term Disability (STD) is granted and procedures for approval and documentation that may be requested by the Company or their Claims Administrator, Sedgwick Claims Management Services, Inc., ("Sedgwick CMS") from an associate or a recognized health care provider under this policy.

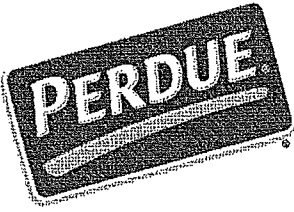
II. ELIGIBILITY/WHEN COVERAGE BEGINS

- A. An associate is eligible if he/she is a regular, full time, associate scheduled to work at least 30 hours per week and has completed the applicable waiting and probation period and if in a Group 4 classification, has elected STD coverage. This policy excludes Milford union live haul drivers.
- B. Group 2, 3, 4 & Chesapeake union associates – Coverage eligibility begins on the first day of the calendar month following one (1) year of service with the Company.
- C. Group 1 – Coverage eligibility begins on the first day of the calendar month on or after the associate's first day of work with the Company.
- D. If an associate is not "actively at work" on the day coverage is scheduled to begin, the coverage will begin when the associate qualifies as being actively at work.

III. DEFINITIONS

- A. Actively At Work- An associate is defined as "actively at work" if the associate is performing the material and substantial duties of his/her regular occupation at the usual work location, an alternate work site or some other location required by the Company on the date coverage is scheduled to begin. An associate is also considered to be actively at work if the date falls on the weekend, holiday or during his/her vacation. If an associate is

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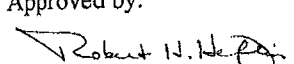
not actively at work on the scheduled date, coverage begins on the date the associate returns to active work with the Company.

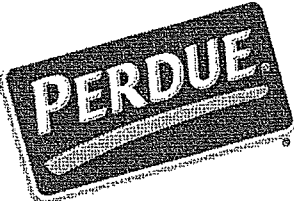
- B. **Disability** - "Disability" means an associate will be considered disabled under the STD Plan if, in accordance with the Plan, the Leave Administrator (Sedgwick CMS), determines that as a result of sickness, injury, or pregnancy, the associate is unable to perform the essential functions of his or her position, or another available position offered for which he or she is qualified, with or without reasonable accommodation. and: the associate is under the appropriate care and treatment as defined by the program; and the disability is supported by objective medical evidence provided by a recognized health care provider.
- C. Reduced schedule and intermittent disability is covered under the same criteria/definition as above.
- D. **Recognized Health Care Provider**- Is defined to include the following for the purpose of this policy: legally qualified Medical Physician (MD or DO), Oral Surgeon, Nurse Practitioner, Certified Nurse Practitioner, or Physician's Assistant licensed to practice in the United States and the state in which the associate is examined or treated.
- E. For the purpose and definition of this policy the following are excluded as recognized health care providers: A Physician who is a member of the associate's immediate family (spouse, father, mother, son, daughter, brother or sister). Chiropractors, Physical Therapists, Licensed Clinical Social Workers, Podiatrists, Dentists, and any and all others not named above, not considered legally qualified physicians for the purpose of this policy.

IV. REPORTING AN ABSENCE

A. Associate's Responsibilities

1. **Notice of Need for Short Term Disability (STD) Benefit.** Associates should notify Sedgwick CMS as soon as possible and must make verbal notice of the need for STD using a toll free number to access the Sedgwick CMS telephonic claims intake center or by web access. (The AT&T language line will be made available for non English speaking Associates.) These forms of notification will serve as the only sufficient

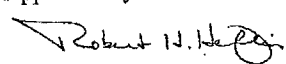
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means to make the Company/Sedgwick CMS aware that the Associate needs STD as well as the anticipated start and duration of STD. Calling in "sick", "late" or "absent" on the "HR call in" number is not considered sufficient notice of the need for STD under this policy. Sedgwick CMS may seek to obtain any additional required information to determine if the reason for absence may be covered by the STD policy. Failure of an Associate to respond to Sedgwick CMS inquiries may result in denial or delay of STD benefits. If an Associate has a planned medical event, they are to notify Sedgwick as soon as they are aware of the timing of the event.

2. **Certification.** An Associate's Family Medical Leave (FML) certification form (Certification of Health Care Provider for Employee's Serious Health Condition) will also serve as initial application for STD benefits if the Associate is eligible and/or has elected STD benefits. The Company/Sedgwick CMS reserves the right to request additional documentation, including medical documentation, to support an Associate's application and continuing eligibility for STD. The Company requires certification for all STD reasons and Sedgwick CMS will issue the appropriate Certification form to the Associate within five business days of when the Associate reports the claim to Sedgwick CMS, and in the case of unforeseen leave, within five business days after the leave commences. This documentation must be returned within 180 days from the first day absent to receive STD payments for Group 4 Associates and 30 days from the first day absent to receive STD payments for Group 1, 2, and 3 Associates. If this documentation is not received within the specified time period, STD payments will be delayed.
3. **Returning To Work.** The associate should report to the location Company Medical Department before beginning any work assignment after Short Term Disability. In accordance with applicable law, and when job-related and consistent with business necessity, the associate may be evaluated by the Company Medical Department to confirm that the associate can perform the essential functions of his or her job, with or without reasonable accommodation. This will be coordinated by the Human Resources department upon notification that the associate will be returning to work.

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B. Supervisor/Team Leader Responsibilities

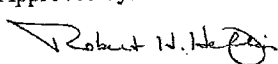
1. When an associate informs the supervisor/team leader that he/she may have a need for STD, the supervisor/team leader should direct the associate to the Sedgwick CMS toll free telephonic intake center or web access or if the supervisor is not aware of the number, direct the associate to Human Resources for assistance.
2. Similarly, if the supervisor/team leader has information that may indicate an associate may have a need for STD or FML leave, the supervisor should either (1) inform the associate that he or she may want to contact Human Resources to inquire about possible STD eligibility or (2) contact Human Resources so that Human Resources can follow up with the associate.

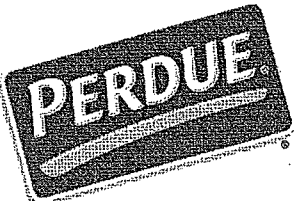
C. Human Resources Responsibilities

1. Communicate and educate as appropriate regarding the Company partnership with Sedgwick CMS for STD administration and direct all associates inquiring about STD regarding their responsibility to make verbal notice of the need for STD using a toll free number to access the Sedgwick CMS telephonic claims intake center or by web access.
2. Communicate the associate's current and ongoing STD status to appropriate Operations Leadership Team Members throughout the course of the STD from initial onset to return to work.
3. Insure that internal HR systems, PeopleSoft and Kronos (where Workforce Attendance Tracking (WAT) has been implemented) are maintained to reflect current STD activity and that the records are consistent with the STD activity provided by Sedgwick CMS. In cases where data is received requiring post dated leave records to be maintained prior to future dated row(s), contact HRMS for assistance.

D. Medical Department Responsibilities

1. If an associate contacts the Medical Department regarding a need for STD, the Medical Department should educate the associate regarding the Company partnership

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with Sedgwick CMS for STD administration and direct the associate to access the Sedgwick CMS telephonic claims center or by web access.

2. Provide appropriate updates to the Operations leadership team and Human Resources personnel regarding the associates return to work status in accordance with HIPAA and Company Medical Department guidelines, in conjunction with information from Sedgwick CMS.
3. Partner with Sedgwick CMS as appropriate through the disability process.

V. WAITING PERIODS/AMOUNT OF COVERAGE

A. Waiting Period

1. Associates may use any available PTO during the STD waiting period. Associates on Other Medical Leave (OML) Policy 214 or (FML) Policy 215 may use any available PTO while on unpaid leave.

Group 1 – No waiting period

Group 2 & 3 – Three (3) scheduled workdays

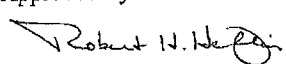
Group 4 – Seven (7) scheduled workdays


2. The waiting period is considered to be continuous days not intermittent days. Partial days will count as full days for purposes of waiting period. No waiting period will apply if the absence begins within 72 hours after an accidental injury requiring more than ordinary first aid or is due to hospitalization. This includes outpatient surgery.

B. Amount of Coverage

Group 1

Service	Weeks at 100%	Weeks at 67%
Less than 5 years	4	22
5 to 9 years	13	13
10 or more years	26	0

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Group 2

Service	Weeks at 100%	Weeks at 67%
1 to 5 years	4	22
5 to 9 years	13	13
10 or more years	26	0

Group 3

Service	Weeks at 75%	Weeks at 50%
1 to 5 years	4	9
5 to 9 years	13	13
10 or more years	26	0

Group 4

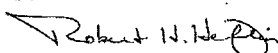
Service	Weeks at 60%	Weeks at 50%
1 to 5 years	4	9
5 or more years	13	0

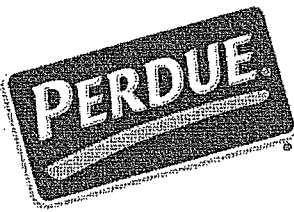
Chesapeake Union

Service	Weeks at 60%	Weeks at 70%
1 to 9 years	13	0
10 years +	0	26

C. **Full Benefit Coverage** - is calculated using the base wage amount effective on last day worked prior to the date of disability. Associates will not be eligible for benefit increases due to wage increase while on disability. Base wage does not include overtime or shift premium. Hourly, salary, and piece rate values will be received in an hourly amount. Piece rate is a 13 week rolling value, calculated by Perdue.

D. **Partial and Intermittent Coverage** - is calculated based on the following: (waiting periods apply) In the event that a recognized health care provider certifies that reduced hours are medically appropriate, the Human Resource Manager will confirm availability of reduced hours work. In the event that the associate cannot be accommodated the associate will remain on STD until they can be returned to full duty. In this event the associate will be

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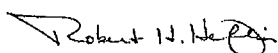
paid for the hours worked under his/her regular pay and the difference between regularly scheduled hours and hours worked under this STD policy. For example: The benefit will pay 4 hrs STD and Perdue will pay 4 hours regular pay.

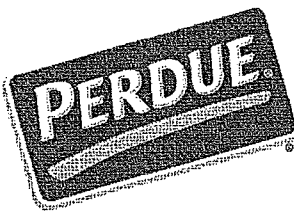
E. **Sample Calculation for Partial Benefits** - If the associate earns \$400 per week at \$10.00 per hour (40 hours scheduled per week) his full disability benefit is 50% (in this particular example) of \$400 or \$200. If the associate worked 3 hrs a day (15 hrs per week) earning \$150 (15 hours * \$10 hourly rate) and 15 hours worked in the week * \$10 earnings per hour = \$150 and if 25 scheduled hours were not worked (40 hours less 15 hours worked); $25 * \$10 * 50\% = \125 partial benefit payment, thus the total payment would be is \$275.

F. **Restricted Duty** - If an associate is released to work with restrictions by a recognized healthcare provider, the Perdue Medical Department, in conjunction with HR, will determine whether the required restrictions can be accommodated. If so, it is a condition of payment that the associate accept the restricted duty. If the restriction cannot be accommodated, the person will remain on STD, FML, or OML until the associate is returned to full duty.

VI. RELAPSE/SUCCESSIVE PERIODS OF DISABILITY

- A. If an associate returns to work from a disability, and then is absent again for the same or related condition or illness, the associate will only be eligible for the amount of short-term disability benefits remaining from the previous disability period. If the subsequent absence begins in less than two (2) weeks from the date the associate returned to work, no waiting period applies. If the subsequent absence begins fifteen (15) or more days from the date the associate returned to work, the associate must satisfy another waiting period. Full short-term disability benefits are reinstated for the same or related injury *or illness* once the associate has returned to work for at least six (6) months.
- B. Each time an associate is unable to work due to an unrelated injury or illness, full short-term disability benefits are payable. Any continuous absence is considered one period of disability for calculation of the maximum benefits payable.
- C. Associates receiving short-term disability benefits, who obtain an additional year of service and therefore would be eligible to move into the next service category, do not

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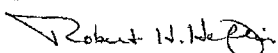
qualify for the additional pay of the higher category due to the associate not being Actively at Work. If the Associate were to take another leave of absence for an unrelated injury or illness, they would then qualify under the higher service category.

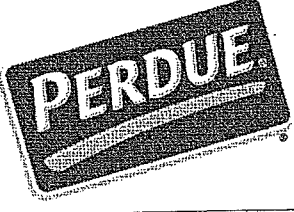
VII. COVERAGE ENDS

Coverage will end under this plan for the following reasons: If the associate is no longer disabled, becomes a member of an ineligible class, is terminated, files for and receives unemployment compensation, upon the day as of which the certified disability ceases, upon termination of the leave program, upon employment layoff, upon plant shut-down, upon position elimination, upon date of retirement, up to and including date of death, at the end of maximum benefit period, upon associate failure to submit proof of disability, upon date no longer disabled, upon associate failure to comply with treatment plan, when the associate is able to return to work in his/her regular occupation or another occupation per disability definition but chooses not to do so.

VIII. EXCLUSIONS AND LIMITATIONS

- A. If an associate becomes ill while on a paid vacation or holiday, short-term disability will not start until the end of the vacation or holiday period. Benefits are not paid if he/she becomes ill or injured while on a personal leave of absence, a military leave of absence, or when he/she is not actively employed with the company.
- B. An associate will exclude him/herself from benefits if he/she is incarcerated in any federal, state or municipal penal institution, jail, medical facility, public or private hospital or in any other place because of a criminal conviction of a federal, state or municipal law or ordinance, or if he/she commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, prosecution of any crime that results in a felony conviction.
- C. Any associate who willfully makes a false material fact in order to obtain benefits under this Program will be excluded from benefits.

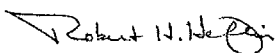
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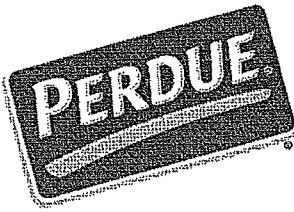
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- D. An associate will be excluded from benefits if she/he fails to place him/herself under a recognized health care provider's care and follow the recommended treatment; Fails to provide information from a recognized health care provider, including objective medical evidence demonstrating disability that is satisfactory to the Claims Administrator (Sedgwick CMS) certifying the associate's disability, including the nature and frequency of treatment; Fails to have a medical examination by a recognized health care provider designated by the Claims Administrator (Sedgwick CMS) and/or fails to provide any additional information when requested, and fails to contact the Claims Administrator (Sedgwick CMS) and obtain written permission if he/she intends to leave home for more than 3 days during his/her disability.
- E. An associate will be excluded from benefits if the disability results in a loss of professional license, occupational license or certification and if said license or certification is required for the job. If the disability as a result in participating in a riot or demonstration it will exclude the associate from the STD benefit.
- F. Any injury or sickness that is caused by, or connected in any way to, employment of the covered Associate outside of Perdue or any FPP company, including self-employment or employment by others is excluded by this benefit. This applies to Worker's Compensation or similar law covers that may cover the disability.
- G. Self-reporting symptoms (self-reporting means the manifestations of a condition which the insured tells their doctor that are not verifiable using tests, procedures, or clinical examination standard accepted in the practice of medicine) are excluded from this benefit. Examples of self-reported symptoms include, but are not limited to headache, pain, fatigue, and stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
- H. Disability as a result of cosmetic surgery is excluded from the benefit except surgery made necessary by accidental injury or by a disabling condition which was incurred while the Participant was covered under the Program. Any complications of cosmetic surgery, or medical or surgical procedures not covered by the Medical Plan are excluded from the benefit.

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IX. DISABILITY BENEFITS FROM OTHER SOURCES

A. SOCIAL SECURITY

If the disability lasts five months or longer, the associate may also be eligible for Social Security disability benefits. In this case, the short-term disability benefits will be reduced by the amount of any Social Security benefits the associate receives.

B. WORKERS' COMPENSATION

1. **SALARIED ASSOCIATES** - If the disability is due to a job-related injury and the associate is receiving Worker's Compensation benefits, the total of both benefits paid will be coordinated so the total amount is equal to no more than the associate's regular bi-weekly salary.
2. **HOURLY ASSOCIATES** - If the disability is due to a job-related injury and the associate is receiving Worker's Compensation benefits, the associate is not eligible to receive any STD benefits.

X. RESPONSIBILITY

The Vice President of Human Resources retains the authority and responsibility for this Policy. Questions concerning the meaning or interpretation of this Policy should be referred to the appropriate Director of Human Resources. Any circumstances that require a waiver from the Policy must be coordinated through the Vice President or Director of Human Resources.

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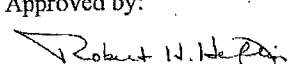
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EXHIBIT B

Perdue STD
2015 Approved Changes
All Changes Effective 1/1/2015

	<u>Current</u>	<u>Change Effective 1/1/2015</u>
Eligibility Waiting Period:	Group 1: First of Month Following 1st Day of Work Groups 2, 3 & 4 : First of Month Following 1 year of service	(no change) First of Month Following 90 Days of Service
Benefit Waiting Period:	Group 1: 0 Days Groups 2 & 3: 3 Days Group 4 7 Days	(no change) (no change) 5 Days
Benefit Duration:	Groups 1, 2 & 3: Up to 26 Weeks, depending on years of service Group 4: Up to 13 Weeks, depending on years of service	(no change) Up to 26 Week, depending on years of service
Contribution:	Groups 1, 2 & 3: noncontributory Group 4: \$3.05 per week	\$3.05 per week (no change)

2015 Maximum Benefit Percentage & Duration by Benefit Group

Years of Service

Maximum Benefit Duration & Amount

SHORT TERM DISABILITY FOR GROUP 1

	WEEKS @ 100%	WEEKS AT 67%
Less than 5 YRS	4	22
5 to 9 YRS	13	13
10 OR MORE YRS	26	

SHORT TERM DISABILITY FOR GROUP 2

	WEEKS @ 100%	WEEKS AT 60%
Less than 5 YRS	4	22
5 to 9 YRS	13	13
10 OR MORE YRS	26	

SHORT TERM DISABILITY FOR GROUP 3

	WEEKS @ 75%	WEEKS @ 50%
Less than 5 YRS	4	22
5 to 9 YRS	13	13
10 OR MORE YRS	26	

SHORT TERM DISABILITY FOR GROUP 4

	WEEKS @ 60%	WEEKS @ 50%
Less than 5 YRS	4	22
5 to 9 YRS	13	13
10 OR MORE YRS	26	

THE PERDUE FARMS INC. VISION PLAN SUMMARY PLAN DESCRIPTION

For associates in these Benefit Groups:

- **1 – Salaried/Exempt**
- **2 – Administrative/Technician – Hourly/Non-exempt**
- **3 – Skilled Labor – Hourly/Non-exempt, Piece Rate**
- **4 – General Labor – Hourly/Non-exempt, Piece Rate**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan oftalmológico de Perdue Farms Inc. Si tiene alguna dificultad para comprender alguna parte de esta SPD, debe llamar a la Línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Effective as of January 1, 2016

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2016, to eligible full-time associates under the Perdue Farms Inc. Vision Plan (referred to here simply as “the Plan”), which is a component of the Perdue Farms Inc. Welfare Benefit Plan. It summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior Vision Plan SPDs.

More detailed information is provided in the Master Policy and Certificate of Insurance, copies of which are available upon request. If there is a difference between how the SPD and the Master Policy and Certificate of Insurance describe the eligibility rules and the benefits being provided under the Plan, the Master Policy and Certificate of Insurance will control and govern the operation of the Plan.

The Company has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the Master Policy and Certificate of Insurance).

Questions regarding your benefits should be addressed to your Human Resources (HR) Department. Participation in the Plan is neither an offer nor a guarantee of future employment.

Decisions Regarding Vision Care

The benefits under the Plan provide solely for the payment of certain vision care expenses. All decisions about vision care are solely your responsibility as a covered individual in consultation with the personal health care provider you selected.

The Master Policy and Certificate of Insurance contain rules for determining the percentage of allowable vision care expenses that will be reimbursed and whether particular vision care expenses are eligible for reimbursement. You may dispute any decision about the level of vision care reimbursement, or the coverage of a particular vision care expense, in accordance with the Plan’s claims procedure. Neither the Plan nor Perdue Farms Inc. (“the Company”) will have any obligation for the cost or legal liability for the outcome of such care, or as a result of your decision not to seek or obtain such care, other than liability under the Plan for the payment of covered benefits.

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Introduction

The Plan helps you pay the cost of a wide range of vision services and supplies. The services and supplies covered, and the amount of benefits available, depend on the type of service or supply.

You may go to a participating vision care provider or a non-participating vision care provider. A higher level of benefits may be available when services are provided by a participating provider since they have agreed to provide a lower rate to Plan members.

If you are an eligible associate, you and your eligible dependents may enroll for coverage under the Plan.

You pay the cost for any coverage you elect under the Plan before taxes, by making an election under the Perdue Farms Inc. Flexible Benefits Plan (the "Flexible Benefits Plan").

Eligibility

This section outlines the Plan's rules of eligibility for both associates and their dependents to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are an associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In one of these Benefit Groups:
 - Benefit Group 1: Salaried/Exempt
 - Benefit Group 2: Administrative/Technician — Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor — Hourly/Non-exempt, Piece Rate
 - Benefit Group 4: General Labor— Hourly/Non-exempt, Piece Rate

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In a job class covered by a collective bargaining agreement and your union does not participate in the Plan;
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Eligible Dependents

You may also enroll your eligible dependents in the Plan. Your eligible dependents are:

- Your legal spouse (including same-sex spouse) or, if grandfathered, your Domestic Partner, as determined under applicable state law and defined under the Internal Revenue Code; and
- Your unmarried dependent children up to age 26. Your children include your children by birth or adoption (or placed with you for adoption), stepchildren, and foster children.

You may continue coverage beyond the Plan's maximum age for an unmarried dependent child who is unable to earn a living because of a mental or physical disability. You must submit proof of your child's disability to the Plan Administrator within 30 days of the child reaching age 26 and from time to time at the request of the Plan Administrator.

Your spouse or child who lives outside the United States or Canada, or who is on active military duty, **is not** your eligible dependent under the Plan.

If You and Your Spouse Work for the Company

If you and your spouse both work for the Company and are both eligible associates, you cannot elect “double coverage” for each other or your eligible children under the Plan.

Either you or your spouse may elect coverage for your dependent children.

Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order.

You must notify the Company and elect coverage for that child, and for yourself if you are not already enrolled, within 30 days of the QMCSO being issued.

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is pursuant to a State domestic relations law (including community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the Plan, and satisfies all of the following:

- The order recognizes or creates the child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a State or political subdivision may be substituted for the child’s mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except an order may require a plan to comply with state laws regarding child health care coverage.

As required by applicable law, the Plan uses procedures to determine whether a medical child support order is qualified. Upon request to the Plan Administrator, you may receive, without charge, a copy of these procedures.

Protection Against Use of Genetic Information

The Plan will not deny, limit or cancel Plan coverage for your or your eligible dependents based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please contact your HR Department. The Perdue Farms Inc. Benefits Committee is the “Claims Fiduciary” for eligibility for the Plan.

Enrollment and Cost

If you want Plan coverage for yourself and any of your eligible dependents, you must enroll. **Coverage is not automatic.** You pay the full cost of any coverage you elect, before taxes, by making an election under the Flexible Benefits Plan. The cost of each coverage category is indicated on your personalized enrollment form and is available on the benefits section of Perdue's intranet site.

Each year during open enrollment, you have the opportunity to make changes to your elections under the Plan. This means any coverage election you make (including no coverage) must remain in effect for up to one year, unless you experience a qualified status change, a special enrollment right, or another event permitting an election change under this Plan or the Flexible Benefits Plan.

Newly-Hired Associates

The following sections outline the steps required to enroll in the Plan and the dates when your coverage under the Plan begins for newly-hired associates.

When and How to Enroll

When you start working for the Company, you will be provided with an enrollment package. The package will include information about your coverage options, their costs, enrollment forms and instructions and the date by which you must make your elections.

You must complete, sign and return your enrollment forms (including any supporting documentation or proof required to be provided) to your HR Department by the dates outlined in your enrollment materials in order to be covered under the Plan.

When Associate Coverage Begins

Coverage begins as follows, if you return your enrollment forms by the date specified in your enrollment materials and are "actively at work" on the date coverage is scheduled to begin.

Benefit Group	When Coverage Begins
1 – Salaried/Exempt	First day of the calendar month on or after your first day of employment with the Company
2 – Administrative/Technician – Hourly/Non-exempt	First day of the calendar month on or after you complete 60 days of employment with the Company
3 – Skilled Labor – Hourly/Non-exempt, Piece Rate	
4 – General Labor – Hourly/Non-exempt, Piece Rate	

What does “actively at work” mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer’s place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day. If you were absent from work due to a health-related factor, you will be considered “actively at work” for this purpose.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

When Dependent Coverage Begins

Coverage for any eligible dependent you elect to enroll begins on the same day your own coverage begins.

Waiving Plan Coverage

You may elect to waive coverage under the Plan by completing the appropriate section on your enrollment form and returning it to your HR Department.

Current Associates — Add or Change Existing Coverage

If you do not enroll for Plan coverage when you are first eligible, or if you enroll and later want to change your coverage, you may enroll or make changes to your existing Plan coverage only under the following circumstances:

- During an open enrollment period in which Plan coverage is offered; or
- After a qualified status change or other event permitting an election change under this Plan or the Flexible Benefits Plan.

Open Enrollment — Additions, Deletions or Changes

During the annual open enrollment period, the enrollment package you receive will include information about the coverage options available to you under the Plan. At that time you will have an opportunity to select the Plan coverage that best meets your needs for the coming year.

If you meet the eligibility rules, you may add or drop coverage for you and/or your eligible dependents during this open enrollment period.

In order to add, drop or change your coverage during the annual open enrollment period, you must complete, sign and return your enrollment forms (including any supporting documentation or proof required) to your HR Department by the dates outlined in your open enrollment materials. Plan elections or changes made during the annual open enrollment period are effective on the first day of the following calendar year, for both eligible associates and their eligible dependent. If you do not elect to make any changes, your current coverage option will continue.

Qualified Status Change and Other Events Permitting an Election Change

You may change your coverage or add eligible dependents during the year if you have a qualified status change or if you experience another event that permits you to change your election under the Plan and the Flexible Benefits Plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of, and corresponds with, the change in status event.

A qualified status change is defined as a change in status that affects your coverage, including the events listed in the following chart:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death. The eligibility status of one dependent affected does not necessarily allow enrolling or dropping enrollment for other dependents.
Employment Status	A termination or commencement of employment, a strike or lockout, return from unpaid leave of absence under FMLA or USERRA, change in worksite or a change in employment status with the gaining or losing eligibility under a health plan by you, your spouse or child.
Work Schedule	A reduction or increase in hours of employment by you, your spouse or a child, including a switch between part-time and full-time.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet the Plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage, change in student status or any similar circumstance.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse or a child that is sufficient to alter provisions of the plan or networks utilized by the plan.
Cost Increase or Decrease	A significant change in the cost of benefits for you, your spouse or your child.
Entitlement to or Loss of coverage through Medicare or Medicaid	If you, your spouse, or child become eligible for or lose coverage through Medicare or Medicaid.

Any change you make must be consistent with the actual event (for example, if you get married, you may add your spouse to your coverage). In order to make a change, you must complete, sign and return an enrollment form to the HR Department within 30 days of the date of the qualifying family status change (for example, dependent birth date, date of marriage or divorce). You must provide proof of the qualifying event (for example, a marriage or dependent birth certificate).

If you change your coverage within 30 days of a qualified family status change, your change is effective as of the date the family status change occurs. If you miss the deadline, you must wait until the next open enrollment period in which Plan coverage is offered to request a change.

When You Have Family Coverage

If you choose the “Associate + Family” enrollment category under the Plan and want to enroll another eligible dependent, you may enroll that dependent in the Plan at any time. However, coverage for the newly-added dependent will begin on the first day of the month after you request that dependent’s enrollment and provide all required documentation within 30 days after the enrollment request. **This option is not available if you choose the “Associate” or “Associate + 1” enrollment category.** Here is an example.

Mark is an associate who chose the “Associate + Family” enrollment category when he joined the Company, but he never specifically enrolled his son Tim for vision coverage. Because Mark chose the “Associate + Family” category, he may enroll Tim in the Plan without a qualified status change, because this change will not affect his before-tax contribution toward the Plan’s cost.

If Mark had chosen the “Associate +1” enrollment category, he would have to wait until the next open enrollment period to enroll Tim in the Plan, because that enrollment would change Mark’s before-tax contribution.

Special Enrollment Periods

In addition to the changes you may make due to a qualified family status change, there are special windows in which you may enroll outside the initial enrollment period or open enrollment period.

Loss of Other Coverage

A special enrollment period applies if you do not elect Plan coverage for yourself and/or your dependents when first eligible because other vision coverage was in effect and:

- The other vision coverage terminates for reasons other than cause (such as a fraudulent claim) or failure to pay premiums; *and*
- You enroll within 30 days of the date the other vision coverage ends.

If you qualify for a special enrollment period, and you return your enrollment form within 30 days of the date the other vision coverage ends, coverage for you and your enrolled eligible dependents will begin on the date your other coverage ends. If you miss the deadline, you must wait until the next open enrollment period to enroll yourself and/or your eligible dependent(s).

New Dependent

A special enrollment period applies if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption and you enroll within 30 days of the event.

Assistance under a Medicaid Plan or State Children’s Health Insurance Plan

If you or your eligible dependent become eligible for assistance under either a Medicaid Plan or a State Children’s Health Insurance Plan (CHIP), you may enroll yourself and eligible dependent

under the Plan, if you request enrollment within 60 days of the date you or your eligible dependent is determined to be eligible for such assistance.

Your Cost

You pay the full cost of coverage under the Plan. Your payroll deduction amount appears on your pay statement. In addition, cost information for all the available options is provided in your initial enrollment package and in the enrollment material distributed each year during open enrollment.

Your contributions are deducted from your pay on a before-tax basis. This means you do not have to pay federal and Social Security taxes (and in most areas, state or local taxes) on your contributions. This can reduce your taxable income and help offset your cost for coverage. Paying for your coverage on a before-tax basis may slightly lower your future Social Security benefit. However, the immediate tax advantages that result from paying for Plan coverage on a before-tax basis are generally greater than any reduction in future Social Security benefits that may occur. Please consult your tax advisor if you have any questions.

A Quick Look at the Options

The Vision Plan provides coverage for a wide range of vision services.

A Member is defined as an eligible Associate or eligible dependent of an Associate who is enrolled and participating in the Vision Plan.

Vision Service	Participating Provider	Non-participating Provider	Frequency of Benefit
Vision Exam With dilation, as necessary	Plan pays 100%, you pay nothing	Plan pays up to \$48, you pay the rest	Once every 12 months
Exam Options			
<ul style="list-style-type: none"> Standard contact lens fit and follow up¹ 	<ul style="list-style-type: none"> You pay up to \$55, Plan pays the rest 	N/A	
<ul style="list-style-type: none"> Premium contact lens fit and follow-up² 	<ul style="list-style-type: none"> You receive 10% discount off retail charge 	N/A	Once every 12 months
Standard Plastic Lenses³			
<ul style="list-style-type: none"> Single Vision 	<ul style="list-style-type: none"> You pay \$20, Plan pays the rest 	<ul style="list-style-type: none"> Plan pays up to \$28, you pay the rest 	
<ul style="list-style-type: none"> Bifocal 	<ul style="list-style-type: none"> You pay \$20, Plan pays the rest 	<ul style="list-style-type: none"> Plan pays up to \$44, you pay the rest 	Once every 12 months
<ul style="list-style-type: none"> Trifocal 	<ul style="list-style-type: none"> You pay \$20, Plan pays the rest 	<ul style="list-style-type: none"> Plan pays up to \$72, you pay the rest 	
Lens Options			
<ul style="list-style-type: none"> Ultra Violet Coating 	<ul style="list-style-type: none"> You pay \$15, Plan pays the rest 	N/A	Once every 12 months
<ul style="list-style-type: none"> Tint (Solid and Gradient) 	<ul style="list-style-type: none"> You pay \$15, Plan pays the rest 		
<ul style="list-style-type: none"> Standard Scratch Resistant 	<ul style="list-style-type: none"> You pay \$15, Plan pays the rest 		
<ul style="list-style-type: none"> Standard Polycarbonate 	<ul style="list-style-type: none"> You pay \$40, Plan pays the rest 		
<ul style="list-style-type: none"> Standard Progressives (add-on to bifocal) 	<ul style="list-style-type: none"> You pay \$85, Plan pays the rest 		
<ul style="list-style-type: none"> Standard Anti-Reflective 	<ul style="list-style-type: none"> You pay \$45, Plan pays the rest 		
<ul style="list-style-type: none"> Other Add-ons 	<ul style="list-style-type: none"> You pay 80% of retail cost, Plan offers 20% discount 		
Frames Any available frame at provider locations	Plan pays up to \$150 and offers 20% discount for amounts above \$150, you pay the rest	Plan pays up to \$55, you pay the rest	Once every 12 months
Contacts Materials only			

¹ Standard Contact Lens Fitting: spherical clear contact lenses in conventional wear and planned replacement (Examples include but are not limited to disposable, frequent replacement)

² Premium Contact Lens Fitting: all lens designs, materials and specialty fittings other than Standard Contact Lens (Examples include toric, multifocal)

³ \$20 materials copayment applies for lenses.

continued next page

Vision Service	Participating Provider	Non-participating Provider	Frequency of Benefit
<ul style="list-style-type: none"> Conventional (in lieu of eyeglass lenses) 	<ul style="list-style-type: none"> Plan pays up to \$125 and offers 15% discount for amounts above \$125, you pay the rest 	<ul style="list-style-type: none"> Plan pays up to \$100, you pay the rest 	Once every 12 months
<ul style="list-style-type: none"> Disposable (in lieu of eyeglass lenses) 	<ul style="list-style-type: none"> Plan pays up to \$125, you pay the rest 	<ul style="list-style-type: none"> Plan pays up to \$100, you pay the rest 	
<ul style="list-style-type: none"> Medically necessary 	<ul style="list-style-type: none"> Plan pays 100% 	<ul style="list-style-type: none"> Plan pays up to \$200, you pay the rest 	
Claims Processing	Your provider submits all necessary paperwork	You must submit an itemized bill along with a claim form	

You are responsible for all applicable taxes.

How the Vision Plan Works

Each time you need vision care, you have the choice of going to a participating vision care provider or a non-participating vision care provider.

Participating EyeMed Vision Providers

Participating providers in the Plan are located in areas convenient to Perdue locations. You may go to any participating provider you choose. Your HR Department can provide you with a list of participating providers in your area. Or go online to www.eyemed.com for a listing of providers.

There are advantages to using a participating provider.

- Participating providers have agreed to charge lower fees to Plan participants.
- You will not have to file any claim forms since participating providers take care of all the paperwork.

Non-Participating EyeMed Vision Providers

You may select a provider who does not participate in the Plan (referred to as an out-of-network or non-participating provider); however, the level of benefits available may be lower. Here is how it works.

- Your non-participating provider may require payment at the time of service.
- You must submit the original, full, itemized invoice along with a properly-completed and signed out-of-network claim form in order to be reimbursed.

Who are participating providers, and how do I find one?

A participating provider is a licensed optometrist, ophthalmologist or optician who participates in the Vision Plan's network of participating providers. Participating providers may change from time to time. For a list of current participating providers, contact your HR Department or visit www.eyemed.com.

Paying Your Share of the Cost

Whether you use a participating or non-participating provider, you are responsible for paying:

- Any required copayment;
- Any charges above the amount covered; and
- Charges for services not covered under the Plan.

What the Vision Plan Covers

This section provides details of the covered vision service expenses under the Plan.

Limits apply to the how often benefits may be paid for each covered vision service under the Plan. These frequency limits are measured on a 12-month basis. For example, the Plan allows for one eye examination every 12 months. If you have an eye examination performed on June 1, you will not be eligible to have another eye examination covered by the Plan until June 1 of the next year.

Vision Examinations

The Plan pays benefits for one vision examination – a comprehensive spectacle eye examination, including dilation – every 12 months.

- **When you use a participating provider**, the Plan pays 100% of covered charges. You pay nothing.
- **When you use a non-participating provider**, you pay the provider all charges, and the Plan reimburses you up to \$48.00, based on the retail cost of the exam.

The Plan also pays benefits every 12 months for contact lens fittings and follow-up services, **but only when you use a participating provider**. A standard contact lens fitting is for spherical clear contact lenses in conventional wear and planned replacement (such as disposable and frequent replacement lenses). A premium contact lens fitting is for all other contact lenses (such as toric, multifocal).

- **For standard contact lens fitting**, you pay up to \$55 of the usual and customary charge, and the Plan pays the rest. Member pays up to \$55 of the usual and customary charge.
- **For premium contact lens fitting**, the Plan offers a 10% discount off the provider's retail charge.

Contact Lens Benefit

The Plan pays benefits for non-disposable, disposable, or medically necessary contact lenses instead of eyeglass lenses, once every 12 months.

- **When you use a participating provider:**
 - For *disposable* contact lenses, the Plan pays \$125, and you pay the rest.
 - For *non-disposable* contact lenses, the Plan pays \$125. For the remaining amount, you pay 85%, and the Plan offers a discount of the remaining 15%.
 - For *medically necessary* contact lenses, the Plan pays 100% of covered charges, and you pay nothing.
- **When you use a non-participating provider:**
 - For *disposable* or *non-disposable* contact lenses, you pay the provider all charges, and the Plan reimburses you up to \$100, based on the retail cost.
 - For *medically necessary* contact lenses, you pay the provider all charges, and the Plan reimburses you up to \$200, based on the retail cost.

Lens Benefit

The Plan pays benefits for standard plastic lenses for single-vision, bifocal or trifocal lenses, once every 12 months.

- **When you use a participating provider**, you pay a \$20 copayment, and the Plan pays the rest.
- **When you use a non-participating provider**, you pay the provider all charges, and the Plan reimburses you up to:
 - \$28.00 for single-vision lenses
 - \$44.00 for bifocal lenses
 - \$72.00 for trifocal lenses

The Plan also pays benefits for certain lens options, once every 12 months, **but only when you use a participating provider**. For these lens options, you pay the copayment amount shown below, and the Plan pays the rest:

- Ultra Violet Coating – \$15.00
- Tint (Solid & Gradient) – \$15.00
- Standard Scratch Resistant – \$15.00
- Standard Polycarbonate – \$40.00
- Standard Progressives (add-on to bifocal) – \$85.00
- Standard Anti-Reflective – \$45.00

For all other add-ons, the Plan provides a 20% discount off the provider's charges.

Frame Benefit

The Plan pays benefits for eyeglass frames once every 12 months.

- **When you use a participating provider**, the Plan pays up to \$150. For the remaining amount, you pay 80%, and the Plan offers a discount of the remaining 20%.
- **When you use a non-participating provider**, you pay the provider all charges, and the Plan reimburses you up to \$55.

What Is Not Covered

Certain services, supplies or charges are not covered under the Plan. Benefits are not provided for services or materials arising from:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structure;
- Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under the Plan;
- Services provided as a result of any Workers' Compensation law;
- Plano (non-prescription) lenses;
- Lenticular lenses;
- Non-prescription sunglasses;
- Two pair of glasses instead of bifocals; or
- Laser vision correction.

Note that certain manufacturers prohibit discounts on frames.

Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balance may be used for additional pairs. The Plan does not pay benefits to replace lost or broken materials.

Additional Discounts Offered by EyeMed

Laser Vision Correction Discounts

While laser vision correction is not a covered benefit under the Plan, you are entitled to a 15% discount (5% discount on promotional pricing) on LASIK and PRK treatments through the U.S.

Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, but you do not use a LasikPlus Center provider for your pre-operative and post-operative care, you must pay the full price of the provider's fees for that pre-operative and post-operative care.

Accessing Laser Vision Correction Discounts

- To locate the nearest U.S. Laser Network provider, call 1-877-5LASER6.
- Contact the U.S. Laser Network provider and identify yourself as an EyeMed member. Schedule a consultation with a U.S. Laser Network provider to determine if you are a good candidate for laser vision correction.
- If you are a good candidate for laser vision correction, schedule a treatment date with a U.S. Laser Network provider.
- To activate the benefit, you must call the U.S. Laser Network again at 1-877-5LASER6 with your scheduled treatment date.
- At the time the treatment is scheduled, you are responsible to remit an initial refundable deposit to U.S. Laser Network. If you decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.
- At the time you remit the deposit, U.S. Laser Network will issue you an authorization number confirming the EyeMed discount. This authorization number will be sent to your U.S. Laser Network provider prior to treatment.
- On the day of the treatment, it is your responsibility to pay or arrange to pay the balance of the fee.
- After the treatment, follow all post-operative instructions carefully. You are responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

Note: Because laser vision correction is not a covered benefit under the Plan, neither the Plan nor the Company has any responsibility for, or authority with regard to, any laser vision care procedure or treatment that you may undergo, and such procedures or treatment are not subject to any of the terms, conditions, or claims procedures of the Plan.

Additional Purchases and Out-of-Pocket Discount

You receive a 20% discount on any remaining balance at participating providers beyond coverage under the Plan, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Providers' professional services, disposable contact lenses or services provided by laser providers. You are also eligible for additional discounts on eyewear purchases. Once the initial benefit has been used, you are eligible for 40% off the retail price of a complete pair eyeglass purchase and 15% off conventional contact lenses. However, a discount is not available on those frames where the manufacturer prohibits a discount.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

If You Are on an Approved Leave of Absence or Approved Disability Leave

Continuing Coverage During Your Leave

If you are on an approved leave of absence (including a leave under the Family and Medical Leave Act) or approved disability leave, your Plan coverage can continue provided you make any required contributions.

- If you are on an approved, **paid** leave (you receive compensation directly from the Company), your contributions to the Plan will continue to be deducted from your paycheck.
- If you are on an approved, **unpaid** leave (you receive either no compensation or you receive compensation from a source other than the Company, such as from a group plan or individual disability insurance policy), your HR Department will send you a letter detailing the payment arrangements.

If you choose to continue Plan coverage during your leave, but you terminate your employment or fail to return from leave and your employment is terminated, your coverage ends on the date on which your employment terminates. When coverage ends, you may be eligible to continue coverage for you and your covered dependents under COBRA (see “Continuation of Coverage Under COBRA”).

Not Continuing Coverage During Your Leave

If you choose not to continue your Plan coverage during your leave, and **your leave is granted under the Family and Medical Leave Act**, you are eligible for your Plan coverage to begin when you return to active work.

If you choose not to continue your Plan coverage during your leave, and **your leave is not granted under the Family and Medical Leave Act**, you will not be eligible for your Plan coverage to begin until the next open enrollment period in which Plan coverage is offered.

Approved Leave of Absence Under Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an associate's military leave of absence. These requirements apply to coverage under the Plan for you and your eligible dependents.

Continuation of Coverage – If you are on an approved military leave of absence, your coverage under the Plan may continue, as long as you make any required premium contributions. For leaves of 31 days or more, you may continue coverage for yourself and your eligible dependents. You continue coverage by paying the required premiums to the Company, until the earliest of the following:

- 24 months from the last day of employment with the Company;
- The day after you fail to return to work; and
- The date the Master Policy and Certificate of Insurance cancel.

For leaves of 31 days or more, the Company may charge you and your eligible dependents up to 102% of the total premium.

Reinstatement of Coverage – If your coverage ends during the leave of absence because you do not elect USERRA continuation coverage and you are re-employed by the Company, coverage for you and your eligible dependents under the Plan may be reinstated if:

- You gave the Company advance written or verbal notice of your military service leave; and
- The duration of all military leaves while you are employed with the Company does not exceed two years.

If your coverage under the Plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

If You Terminate Your Employment

Your coverage under the Plan ends on the day your employment terminates, whether or not your termination was due to your failure to return from a leave of absence. When coverage ends, you may be eligible to continue coverage for yourself and your eligible covered dependents under COBRA (see “Continuation of Coverage Under COBRA”).

If You Gain a New Dependent

If you gain a new dependent (for example, through marriage, birth or adoption), you may enroll your new dependent for coverage if you do so within 30 days of the date he or she becomes your eligible dependent and if you provide the Company with documentation that may be required by the Plan Administrator in order to verify the person’s status as your dependent.

If a Dependent Loses Eligibility

If a dependent no longer meets the eligibility requirements, he or she may be able to continue coverage under COBRA (see “Continuation of Coverage Under COBRA”). To continue coverage under COBRA, you or your dependent must notify your HR Department within 30 days of the date your dependent stops being an eligible dependent.

If You Die

If you die, coverage for your dependents ends. However, your eligible covered dependents may continue coverage for up to 36 months under COBRA (see “Continuation of Coverage Under COBRA”).

Claims

Before you go to a participating provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification card to allow the provider to file claims for you. EyeMed Vision Care Customer Service can be reached Monday through Saturday from 7:30 a.m. to 11:00 p.m. Eastern time, and Sunday 11:00 a.m. to 8:00 p.m. Eastern time, at 866-723-0513.

EyeMed claims are handled through First American Administrators (“FAA”). First American Administrators “FAA” is a wholly-owned subsidiary of EyeMed.

Filing Claims

One of the advantages of using participating providers under the Plan is that you do not need to submit claim forms. When you use a non-participating provider, however, you must file a claim form to be reimbursed.

If You Use a Participating Vision Care Provider

Participating providers in the Plan’s Vision Plus network file vision claims for you automatically. After the Claims Administrator receives a claim, it determines the benefits and sends payment directly to the participating provider. In most cases, you will only be billed for any applicable copayment amount. However, you are responsible for paying any charges that are not covered by the Plan.

If You Use a Non-participating Vision Care Provider

If you use a non-participating provider (one who does not participate in the Vision Plus network), you may be required to pay the provider at the time of service. You also need to submit the original, full, itemized invoice with a complete and signed claim form to request reimbursement of covered expenses.

To file for reimbursement:

- Obtain a claim form from your HR Department (also available on the Perdue Intranet), or online at www.eyemed.com.
- Follow the instructions printed on the form.
- Attach the original vision care provider’s full, itemized bill.
- Submit the completed form to the address printed on the form.

Your claim will be evaluated to determine if any benefits will be paid. You will receive an explanation of benefits (EOB) statement. If benefits are payable, a check is sent to you directly from the Claims Administrator.

If your claim is denied, you may appeal the decision; see “Appealing a Claim.”

Filing Deadlines

You should submit claims as soon as possible after the date the service is provided. **No benefits** will be paid for claims submitted more than 12 months after the date of service.

Pre-Service Claim

A pre-service claim is any claim for a benefit under the Plan with respect to which the Claims Administrator requires you to obtain approval of the benefit in advance of receiving the care. If your claim is incomplete, the Claims Administrator will notify you of their procedures for a pre-service claim, and your failure to follow them within five days after its receipt of your deficient claim if your attempt at filing:

- Is communicated by you or your authorized representative to the Claims Administrator; and
- Names your specific health condition or symptom and a specific treatment, service or product for which approval is requested.

If the information you supply is not enough for the Claims Administrator to decide a pre-service claim, the Claims Administrator will notify you of the deficiency and the information you need to complete the claim within five days. You must provide the requested information within 45 days after the Claims Administrator notifies you of the deficiency. The Claims Administrator will then notify you of its decision within 15 days (may be extended to 30 days with notice to you).

Post-Service Claim

A post-service claim is any claim for a benefit for health care already rendered.

Concurrent Care Claims

At times, the Claims Administrator for Plan benefits may approve an ongoing course of treatment to be provided over a period of time or number of treatments.

If the Claims Administrator later reduces or no longer covers a previously approved course of treatment before the end of the approved period of time or treatments, the Claims Administrator will notify you of the adverse benefit determination sufficiently in advance of the reduction or elimination of coverage to allow you to appeal and obtain a determination before the benefit is reduced or eliminated.

If you wish to extend a course of treatment and your claim is for non-urgent, concurrent care, the Claims Administrator will notify you of its decision within 15 days of its receipt of your claim. Otherwise, a decision will be issued according to the category your claim falls into at the time it is made (i.e., pre-service or post-service). If your claim is denied, you may appeal the decision.

Decisions on Claims

You will receive a decision on your claim in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

In the case of health benefits, the written denial notice also informs you of:

- Any specific rule, guideline or protocol that was relied upon or a statement that such rule, guideline or protocol was relied upon and that you may request a copy of it free of charge; and
- If the adverse determination is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment or a statement that you may request such explanation free of charge.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan Administrator's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination;
- Demonstrate compliance with the Plan Administrator's processes or safeguards; and
- In the case of health benefits, constitute a statement of the Plan Administrator's policy or guideline regarding the benefit for your diagnosis, whether relied upon or not.

Appealing a Claim

The Plan wants to be sure that you and your covered dependents and beneficiaries receive the full benefits for which you or they are eligible under each of the benefits in the Plan.

If an initial claim for benefits under the Plan is denied, in whole or in part, in an Explanation of Benefits form, a letter from a Claims Administrator or otherwise, you have 180 days to appeal the denial. Your appeal must be in writing and should contain the reasons why you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits.

You will receive a decision on appeal in writing as described in the section "Decisions on Claims."

The applicable decision makers consider your request for review and notify you of their decision within the following time periods:

- Pre-service claims: 30 days of receipt of your appeal; and
- Post-service claims: 60 days of receipt of your appeal.

Special Rule When Decision Is Based on Medical Judgment

When a denial on appeal is based on a medical judgment, the Claims Administrator consults with a health care professional with appropriate training, who will be identified upon request. Such health care professional will be someone who was neither consulted in connection with the initial denial of a claim that is subject to the appeal, nor the subordinate of any such individual.

The final decision on appeal is sent to you in writing and will inform you of the specific reasons for the decision and the specific provision of the Plan upon which the decision is based. Except as required by law, the decisions are final and binding on all parties. You and your covered

dependents must exhaust all the internal administrative remedies described above prior to bringing an action for benefits under the plans under Section 502(a) of ERISA.

When Coverage Ends

This section outlines when coverage ends. When coverage ends, you may be able to continue coverage for a limited period of time under COBRA.

When Associate Coverage Ends

Your coverage ends on the earliest date one of the following events occur:

- The day you stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Plan is terminated;
- You elect to terminate coverage under the Plan due to a qualified status change or other event permitting an election change; or
- You fail to pay any required premiums.

When your coverage ends, you may be able to continue Plan coverage under COBRA.

When Dependent Coverage Ends

In most cases, dependent coverage ends on the date your coverage ends. It also ends on the earliest date one of the following events occur:

- The first day your covered dependent is no longer eligible; or
- You fail to pay any required premiums.

You *must* notify your HR Department within 30 days of the date that your dependent no longer qualifies as an eligible dependent. Information about continuing coverage under COBRA will be sent to your dependent.

Continuing Coverage

When coverage ends for you and/or a covered dependent, you may have an opportunity to continue coverage beyond the time it would otherwise end.

Continuation of Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your eligible dependent(s) may be eligible to continue health coverage if you or your eligible dependent(s) coverage ends because of certain “qualifying events.” The following information outlines the continuation of coverage available under COBRA.

COBRA requires most employers who sponsor group health care plans to provide a temporary extension of coverage to associates and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer’s plan. Under COBRA, you (or your dependents) will generally be permitted to continue the same coverage that you (or your dependents) had prior to the event that would otherwise cause the loss of coverage. This temporary extension of benefits is commonly called “continuation coverage.”

Here is a summary of who is eligible for continuation coverage under COBRA, when they become eligible, and for how long the coverage may continue:

These people	May continue coverage if it is lost due to...	For up to...
Associate	<ul style="list-style-type: none">• Reduction in associate’s hours of employment• Termination of associate’s employment for any reason other than gross misconduct• Failure to return from a leave of absence under the Family and Medical Leave Act of 1993	<ul style="list-style-type: none">• 18 months• 18 months• 18 months
Covered spouse of an associate	<ul style="list-style-type: none">• Reduction in associate’s hours of employment• Termination of associate’s employment for any reason other than gross misconduct• Associate’s failure to return from a leave of absence under the Family and Medical Leave Act of 1993• Death of associate• Divorce or legal separation• Associate becomes entitled to Medicare and elects Medicare as primary provider	<ul style="list-style-type: none">• 18 months• 18 months• 18 months• 36 months• 36 months• 36 months

These people	May continue coverage if it is lost due to...	For up to...
Covered dependent child(ren) of an associate	<ul style="list-style-type: none"> • Reduction in associate's hours of employment • Termination of associate's employment for any reason other than gross misconduct • Associate's failure to return from a leave of absence under the Family and Medical Leave Act of 1993 • Death of associate • Associate's divorce or legal separation • Associate becomes entitled to Medicare and elects Medicare as primary provider • Loss of dependent status under the Plan 	<ul style="list-style-type: none"> • 18 months • 18 months • 18 months • 36 months • 36 months • 36 months • 36 months

When COBRA Coverage May Continue Beyond 18 Months

If a covered person has an 18-month qualifying event and the Social Security Administration determines that person to be disabled at any time during the first 60 days of continued COBRA coverage, coverage for you and your dependents may be extended from 18 months to 29 months.

- If the disabled person recovers and is no longer disabled, you must notify the COBRA Administrator within 30 days, and COBRA coverage may be continued only for the remainder of the original 18-month period.
- If the disabled person recovers after the end of the original 18-month period, COBRA coverage will end on the last day of the month in which the person is no longer disabled.

If during an 18-month continuation period a second qualifying event occurs that entitles your dependent to COBRA coverage, your dependent's coverage may be extended by another 18 months. You must notify the COBRA Administrator within 60 days of the second qualifying event. But in no case will COBRA coverage continue for more than 36 months from the first qualifying event.

The 18, 29 or 36 months of continuation coverage begins on the date of the event that causes loss of coverage.

Qualified Beneficiaries

Individuals who are eligible for COBRA coverage are called "qualified beneficiaries." The events that entitle them to coverage are called "qualifying events." Generally, to be a qualified beneficiary, you must have health coverage under the Plan on the day before a qualifying event occurs; however, a child born to, adopted by or placed for adoption with you during the continuation coverage period is also a "qualified beneficiary."

Loss of Coverage

When a qualifying event occurs, you and the Company have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, you or your eligible dependent must notify the COBRA Administrator in writing within 60 days of the qualifying event. The COBRA Administrator will know if the event is death, termination of employment, reduction in hours, failure to return from a leave of absence under the Family and Medical

Leave Act of 1993, entitlement to Medicare benefits or the commencement of a bankruptcy proceeding.

When the COBRA Administrator is notified or learns of a qualifying event, the Plan Administrator will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You then have 60 days from the later of the date of this explanation or the date on which your existing coverage would end to notify the COBRA Administrator of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

COBRA Election

Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one eligible dependent may make an election that covers some or all of the others.

If you elect to continue coverage:

- *You must pay a total premium equal to the group rate plus a 2% administration charge monthly (or such higher charge as may be permitted by law)*.*
- The total premium includes the contribution an active participant must make under the Plan.
- The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for months after your election must be paid within 30 days of the date due. Premium rates may change periodically for all qualified beneficiaries.

The coverage provided will be identical to the coverage provided similarly-situated associates or dependents. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

* If you or your covered dependent is eligible for the additional 11 months of coverage because of disability, the premium for the additional 11 months is increased to 150% of the group rate. This increased premium may also apply through the 36th month if a second qualifying event later extends the continuation period to 36 months.

Benefits for Eligible Dependents

Unless otherwise specified in the election, any election of continuation coverage made by you or your spouse or former spouse will be considered to be an election of continuation coverage for any eligible dependent who would also lose coverage by reason of the qualifying event. If you elect continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of benefits until the next open enrollment period. At that time, they may change their coverage if they wish.

However, if you decide not to continue your coverage at all, or if you elect to continue coverage just for yourself (and not for your dependents), then each eligible dependent may make an independent benefit selection.

Changes to Continuation Coverage

Qualified beneficiaries have the same opportunities to change coverage as active associates during the annual open enrollment period. During open enrollment, you may elect different coverage or add or delete dependents, as if you were an active associate.

When COBRA Benefits End

Generally, continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart earlier in this section. However, COBRA benefits will end immediately if:

- The person whose coverage is being continued fails to pay the premium on time;
- The person whose coverage is being continued becomes covered under another employer's group health plan, unless the other group health plan contains an exclusion or limitation with respect to a pre-existing condition of the person (other than an exclusion or limitation which does not apply to [or is satisfied by] the person under applicable provisions of federal law);
- The person whose coverage is being continued becomes entitled to Medicare benefits (this does not apply if you are entitled to purchase continuation coverage due to commencement of a bankruptcy proceeding by the Company);
- In the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the person is no longer disabled under the Social Security laws*; or
- The Company no longer maintains a group health plan covering any associate.

* A qualified beneficiary is responsible for notifying the COBRA Administrator within 30 days of the date of a final determination that he or she is no longer disabled under the Social Security laws.

Two Qualifying Events

An 18-month or 29-month period of continuation coverage may be extended if another qualifying event (other than a bankruptcy proceeding) occurs during that time. However, no one may extend coverage for more than 36 months. The 36-month period is counted from the first event. For example, if your employment ends and you get divorced during the 18-month continuation period for which you have elected continuation coverage for you and your dependents, your dependents may extend coverage for up to 36 months from the date your employment ended. In addition, if you become entitled to Medicare benefits and during the subsequent 18-month period lose coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than you will be entitled to a maximum of 36 months of coverage from the date of your Medicare entitlement, subject to the rules regarding earlier termination of COBRA continuation coverage. You remain entitled to 18 months of continuation coverage from the date of your termination of employment or a reduction in hours of employment. To qualify for this extension, you must notify the COBRA Administrator in writing within 60 days of the event.

Converting Coverage to an Individual Policy

This option is not available under the Plan.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue Plan coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim

for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Vision Plan is fully-insured through an insurance contract with EyeMed Vision Care and underwritten by Fidelity Security Life Insurance Company. Participating associates and the Company share the cost of the Plan.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an “at-will employee,” either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the Master Policy and Certificate of Insurance that determine your rights and the rights of your dependents under the Plan. In the event of a discrepancy between this summary plan description and the Master Policy and Certificate of Insurance, the Master Policy and Certificate of Insurance will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan, the Master Policy and Certificate of Insurance, or other documents maintained in conjunction with the Plan.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Limits on Assignment of Benefits

To the extent permitted by law, and except where specified under the terms of the Plan, no benefits will be subject to assignment, alienation, sale, transfer, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. However, your benefits may be subject to a Qualified Medical Child Support Order.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the Master Policy and the Certificate of Insurance). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to

interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan shall be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Vision Plan Identification

Plan Name	The official Plan name is the Perdue Farms Inc. Vision Plan.
Plan Sponsor	The Plan Sponsor is Perdue Farms Inc.
Type of Administration	EyeMed (First American Administrators, Inc.) acting as Claims Administrator under a fully insured contract.
Plan Administrator	The Plan Administrator is: The Perdue Benefits Committee Perdue Farms Inc. 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
Claims Administrator	The Claims Administrator for benefits under the Perdue Farms Inc. Vision Plan is: First American Administrators, Inc., a wholly owned subsidiary of: EyeMed Vision Care, LLC 4000 Luxottica Place Mason, OH 45040 1-866-723-0513
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Farms Inc. Vision Plan is: The Perdue Benefits Committee Perdue Farms Inc. 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000
COBRA Administrator	Mangrove Health Services 1501 South Church Ave. Tampa, FL 33629 1-888-862-6272
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.
Plan Records and Plan Year	The Perdue Farms Inc. Vision Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.
Type of Plan	The Perdue Farms Inc. Vision Plan, which is a component of the Perdue Farms Inc. Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
Plan Number	The Plan Number is 502
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.

THE PERDUE FARMS INC. DENTAL PLAN SUMMARY PLAN DESCRIPTION

For associates in these Benefit Groups:

- **1 – Salaried/Exempt**
- **2 – Administrative/Technician – Hourly/Non-exempt**
- **3 – Skilled Labor – Hourly/Non-exempt, Piece Rate**
- **4 – General Labor – Hourly/Non-exempt, Piece Rate**

La Descripción resumida del plan (SPD, por sus siglas en inglés) contiene un resumen en inglés de sus derechos y beneficios en virtud del Plan odontológico de la compañía "Perdue Farms Inc." Si tiene alguna dificultad para comprender alguna parte de éste SPD, debe llamar a la línea de beneficios corporativos al 1-800-997-3247 para obtener ayuda.

Effective as of January 1, 2018

Preface

This is a Summary Plan Description (SPD) of the benefits available, effective January 1, 2018, to eligible full-time associates under the Perdue Farms Inc. Dental Plan (referred to here simply as “the Plan”), which is a component of the Perdue Farms Inc. Welfare Benefit Plan. It summarizes the benefits currently available under the Plan and explains in non-technical language how the Plan works, and it replaces all prior Dental Plan SPDs. The Plan includes several different coverage options. The services covered and the amount of benefits available depend on the coverage option you choose.

More detailed information is provided in the plan documents for the Plan, copies of which are available upon request. If there is a difference between how the SPD and the plan documents describe the eligibility rules and the benefits being provided under the Plan, the plan documents will control and govern the operation of the Plan.

The Company has the right to modify, suspend, change or terminate the Plan at any time (subject to the terms of the plan documents).

Questions regarding your benefits should be addressed to your Human Resources (HR) Department. Participation in the Plan is neither an offer nor a guarantee of future employment.

Decisions Regarding Dental Care

The benefits under the Plan provide solely for the payment of certain dental care expenses. All decisions about dental care are solely your responsibility as a covered individual in consultation with the personal health care provider you selected.

The plan documents contain rules for determining the percentage of allowable dental care expenses that will be reimbursed and whether particular dental care expenses are eligible for reimbursement. You may dispute any decision about the level of dental care reimbursement, or the coverage of a particular dental care expense, in accordance with the Dental Plan’s claims procedure. Neither the Plan nor Perdue (“the Company”) will have any obligation for the cost or legal liability for the outcome of such care, or as a result of your decision not to seek or obtain such care, other than liability under the Plan for the payment of covered benefits.

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INTRODUCTION

The Plan helps you pay the cost of a wide range of dental services and supplies. The services and supplies covered, and the amount of benefits available, depend on the type of service or supply.

There are three coverage options offered under the Plan: Basic Dental option, Dental Plus option, and Dental Plus with Orthodontics option. These options, as well as the schedule of benefits associated with them, are explained in more detail in later sections of this SPD.

If you are an eligible associate, you and your eligible dependents may enroll for coverage under one of the coverage options.

You may go to a participating dentist or a non-participating dentist. Within each coverage option, the Plan pays the same percentage of benefits for covered expenses regardless of the dentist used. However, your share of the cost of care may be less when you use participating dentists because they have agreed to provide a lower rate to Plan members.

You pay the cost for any coverage you elect under the Plan before taxes, by making an election under the Perdue Farms Inc. Flexible Benefits Plan (the "Flexible Benefits Plan").

Eligibility

This section outlines the Plan's rules of eligibility for both associates and their dependents to elect coverage.

Eligible Associates

You are eligible to participate in the Plan if you are an associate of the Company who is:

- Full-time, meaning your position requires you to work at least 30 regularly scheduled hours a week; *and*
- In one of these Benefit Groups:
 - Benefit Group 1: Salaried/Exempt
 - Benefit Group 2: Administrative/Technician – Hourly/Non-exempt
 - Benefit Group 3: Skilled Labor – Hourly/Non-exempt, Piece Rate
 - Benefit Group 4: General Labor – Hourly/Non-exempt, Piece Rate

Your HR Department can tell you which Benefit Group applies to you.

You are *not* an eligible associate if you are:

- In a job class covered by a collective bargaining agreement that does not provide for coverage under this Plan;
- A leased employee;
- Classified by the Company as a contract worker, independent contractor, or temporary employee, whether or not you are on the Company's W-2 payroll or are determined by the IRS or others to be a common-law employee of the Company;
- A non-resident alien with no income from sources within the U.S.; or
- Performing services for the Company but paid by a temporary or other employment or staffing agency for the period during which you are paid by such agency, whether or not you are determined by the IRS or others to be a common-law employee of the Company.

Eligible Dependents

You may also enroll your eligible dependents in the Plan. Your eligible dependents are:

- Your legal spouse (including a same-sex spouse); and
- Your dependent children to age 26.

Your children include your children by birth or adoption (or placed with you for adoption), stepchildren, and foster children.

You may continue coverage beyond the Plan's maximum age for an unmarried dependent child who is unable to earn a living because of a mental or physical disability. You must submit proof of your child's disability to the Plan Administrator within 30 days of the child reaching age 26, and from time to time at the request of the Plan Administrator.

Your spouse or child who lives outside the United States or Canada, or who is on active military duty, **is not** your eligible dependent under the Plan.

If You and Your Spouse Work for the Company

If you and your spouse both work for the Company and are both eligible associates, you cannot elect “double coverage” for each other or your eligible children under the Plan. Instead, both you and your spouse must make separate enrollment elections for the Plan. Neither of you may cover the other as your dependent spouse.

Either you or your spouse may elect coverage for your dependent children.

Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order.

You must notify the Company and elect coverage for that child, and for yourself if you are not already enrolled, within 30 days of the QMCSO being issued.

A QMCSO is a judgment, decree, or order (including approval of a settlement agreement) or administrative notice, which is pursuant to a State domestic relations law (including community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the Plan, and satisfies all of the following:

- The order recognizes or creates the child's right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a State or political subdivision may be substituted for the child's mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except for an order that may require a plan to comply with state laws regarding child health care coverage.

As required by applicable law, the Plan uses procedures to determine whether a medical child support order is qualified. Upon request to the Plan Administrator, you may receive, without charge, a copy of these procedures.

Protection Against Use of Genetic Information

The Plan will not deny, limit, or cancel Plan coverage for you or your eligible dependents based on genetic information.

Questions About Eligibility?

If you have questions about eligibility for you or your family member, please contact your HR Department. The Perdue Farms Inc. Benefits Committee is the “Claims Fiduciary” for eligibility for the Plan.

ENROLLMENT AND COST

If you want Plan coverage for yourself and any of your eligible dependents, you must enroll. **Coverage is not automatic.** You and the Company share the cost of any coverage you elect, before taxes, by making an election under the Flexible Benefits Plan. The cost of each coverage category is indicated on your personalized enrollment form and is available on the benefits section of Perdue's intranet site.

Plan election changes are offered every year during an open enrollment period. This means any coverage election you make (including no coverage) must remain in effect for up to one year, unless you experience a qualified status change, a special enrollment right, or another event permitting an election change under this Plan or the Flexible Benefits Plan.

The coverage option you choose for yourself must also apply to the eligible dependents you enroll.

Newly-Hired Associates

The following sections outline the steps required to enroll in the Plan and the dates when your coverage under the Plan begins for newly-hired associates.

When and How to Enroll

When you start working for the Company, you will be provided with an enrollment package. The package will include information about your coverage options, their costs, enrollment forms, and instructions and the date by which you must make your elections.

You must complete, sign and return your enrollment forms (including any supporting documentation or proof required to be provided) to your HR Department by the dates outlined in your enrollment materials in order to be covered under the Plan.

When Associate Coverage Begins

Coverage begins as follows, if you return your enrollment forms by the date specified in your enrollment materials and are "actively at work" on the date coverage is scheduled to begin.

Benefit Group	When Coverage Begins
1 – Salaried/Exempt	First day of the calendar month on or after your first day of employment with the Company
2 – Administrative/Technician – Hourly/Non-exempt	First day of the calendar month on or after you complete 60 days of employment with the Company
3 – Skilled Labor – Hourly/Non-exempt, Piece Rate	
4 – General Labor – Hourly/Non-exempt, Piece Rate	

What does “actively at work” mean?

You must be actively at work for coverage or a benefit increase (if applicable) to take effect. You are considered actively at work if you are performing the regular duties of employment on that day either at the employer’s place of business or at some location to which you are required to travel for the Company.

You are considered to be actively at work on each day of a regular paid vacation and on each regular non-work day, if you were actively at work on the last preceding regular work day. If you were absent from work due to a health-related factor, you will be considered “actively at work” for this purpose.

If you are not actively at work on that day, your coverage or benefit increase begins on the date that you return to active work with the Company.

When Dependent Coverage Begins

Coverage for any eligible dependent you elect to enroll begins on the same day your own coverage begins.

Waiving Plan Coverage

You may elect to waive coverage under the Plan by completing the appropriate section on your enrollment form and returning it to your HR Department.

Current Associates - Add or Change Existing Coverage

If you do not enroll for Plan coverage when you are first eligible, or if you enroll and later want to change your coverage, you may enroll or make changes to your existing Plan coverage only under the following circumstances:

- During an open enrollment period in which Plan coverage is offered; or
- After a qualified status change or other event permitting an election change under this Plan or the Flexible Benefits Plan.

Open Enrollment – Additions, Deletions, or Changes

During the annual open enrollment period, the enrollment package you receive will include information about the coverage options available to you under the Plan. At that time you will have an opportunity to select the Plan coverage that best meets your needs for the coming year.

If you meet the eligibility rules, you may add or drop coverage for you and/or your eligible dependents during this open enrollment period.

In order to add, drop or change your coverage during the annual open enrollment period, you must complete, sign and return your enrollment forms (including any supporting documentation or proof required) to your HR Department by the dates outlined in your open enrollment materials. Plan elections or changes made during the annual open enrollment period are effective on the first day of the following calendar year, for both eligible associates and their eligible dependents.

Qualified Status Change and Other Events Permitting an Election Change

You may change your coverage or add eligible dependents during the year if you have a qualified status change or if you experience another event that permits you to change your election under the Plan and the Flexible Benefits Plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is on account of, and corresponds with, the change in status event.

A qualified status change is defined as a change in status that affects your coverage, including the events listed in the following chart:

Qualified Status Change	Description
Marital Status	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment.
Number of Family Members	Events that change the number of eligible family members, including birth, adoption, placement for adoption or death. The eligibility status of one dependent affected does not necessarily allow enrolling or dropping enrollment for other dependents.
Employment Status	A termination or commencement of employment, a strike or lockout, return from unpaid leave of absence under FMLA or USERRA, change in worksite or a change in employment status with the gaining or losing eligibility under a health plan by you, your spouse or child.
Work Schedule	A reduction or increase in hours of employment by you, your spouse or a child, including a switch between part-time and full-time.
Family Member Meets or No Longer Meets the Eligibility Requirements	An event that causes a member of your family to meet or to no longer meet the Plan's eligibility requirements for coverage. This may include a child reaching the maximum age for coverage, change in student status or any similar circumstance.
Residence or Worksite	A change in the place of residence or worksite of you, your spouse or a child that is sufficient to alter provisions of the plan or networks utilized by the plan.
Cost Increase or Decrease	A significant change in the cost of benefits for you, your spouse or your child.
Entitlement to or Loss of coverage through Medicare or Medicaid	If you, your spouse, or child become eligible for or lose coverage through Medicare or Medicaid.

Any change you make must be consistent with the actual event (for example, if you get married, you may add your spouse to your coverage). In order to make a change, you must complete, sign and return an enrollment form to the HR Department within 30 days of the date of the qualifying family status change (for example, dependent birth date, date of marriage or divorce). You must provide proof of the qualifying event (for example, a marriage or dependent birth certificate).

If you change your coverage within 30 days of a qualified family status change, your change is effective as of the date the family status change occurs. If you miss the deadline, you must wait until the next open enrollment period in which Plan coverage is offered to request a change.

Special Enrollment Periods

In addition to the changes you may make due to a qualified family status change, there are special windows in which you may enroll outside the initial enrollment period or open enrollment period.

Loss of Other Coverage

A special enrollment period applies if you do not elect Plan coverage for yourself and/or your dependents when first eligible because other dental coverage was in effect and:

- The other dental coverage terminates for reasons other than cause (such as a fraudulent claim) or failure to pay premiums; and
- You enroll within 30 days of the date the other dental coverage ends.

If you qualify for a special enrollment period, and you return your enrollment form within 30 days of the date the other dental coverage ends, coverage for you and your enrolled eligible dependents will begin on the date your other coverage ends. If you miss the deadline, you must wait until the next open enrollment period to enroll yourself and/or your eligible dependent(s).

New Dependent

A special enrollment period applies if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption and you enroll within 30 days of the event.

Assistance under a Medical Plan or State Children's Health Insurance Plan

If you or your eligible dependent become eligible for assistance under either a Medicaid Plan or a State Children's Health Insurance Plan, you may enroll yourself and eligible dependent under the Plan, if you request enrollment within 60 days of the date you or your eligible dependent is determined to be eligible for such assistance.

Your Cost

You and the Company share the cost of coverage under the Plan. Your payroll deduction amount appears on your pay statement. In addition, cost information for all the available options is provided in your initial enrollment package and in the enrollment material distributed each year during open enrollment.

Your contributions are deducted from your pay on a before-tax basis. This means you do not have to pay federal and Social Security taxes (and in most areas, state or local taxes) on your contributions. This can reduce your taxable income and help offset your cost for coverage. Paying for your coverage on a before-tax basis may slightly lower your future Social Security benefit. However, the immediate tax advantages that result from paying for Plan coverage on a before-tax basis are generally greater than any reduction in future Social Security benefits that may occur. Please consult your tax advisor if you have any questions.

A Quick Look at the Options

The Plan provides coverage for a wide range of dental services. You may choose one of three coverage options: Basic Dental, Dental Plus, or Dental Plus with Orthodontics. The services covered – and the amount of benefits available – depend on the option and the type of service or supply.

Comparing the Options

This chart summarizes the benefits available under each option. A more detailed list of covered services is provided later in the SPD. **Please note:** If you use a non-participating dentist, you must pay amounts above the Plan's allowed amount in addition to your regular share of expenses. Charges above the Plan's allowed amount are not a covered expense.

Dental Plan Coverage Options	Basic Dental	Dental Plus	Dental Plus with Orthodontics
Preventive and Diagnostic Services, such as: <ul style="list-style-type: none"> Sealants Space maintainers Fluoride treatments X-rays Cleanings 	Plan pays 100% of allowed amount, you pay nothing	Plan pays 100% of allowed amount, you pay nothing	Plan pays 100% of allowed amount, you pay nothing
Basic Restorative Services, such as: <ul style="list-style-type: none"> Fillings (silver and "white" non-molar teeth) 	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount
Major Restorative Services, such as: <ul style="list-style-type: none"> Crowns Inlays Onlays 	Not covered – you pay all charges	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount
Oral Surgery, such as: <ul style="list-style-type: none"> Extractions Oral surgery 	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount
Endodontics Includes pulpal therapy, root canal therapy	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount
Periodontics Includes surgical and nonsurgical treatment of gums and supporting structures of teeth	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount	You pay the annual deductible, Plan pays 80% of allowed amount, and you pay 20% of allowed amount

Dental Plan Coverage Options	Basic Dental	Dental Plus	Dental Plus with Orthodontics
Prosthodontics , such as: <ul style="list-style-type: none"> Fixed bridges Partial or complete dentures Repair of fixed bridges and partial or complete dentures 	Not covered – you pay all charges	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount	You pay the annual deductible, Plan pays 50% of allowed amount, and you pay 50% of allowed amount
Orthodontics Includes straightening of teeth for children to age 26	Not covered – you pay all charges	Not covered – you pay all charges	You pay the \$50 lifetime orthodontics deductible (per child), Plan pays 50% of allowed amount up to the lifetime orthodontics maximum benefit, and you pay the rest
Annual Deductible Applies to all covered expenses except preventive and diagnostic services and orthodontic services	<ul style="list-style-type: none"> \$25 per person per calendar year \$75 per family per calendar year 	<ul style="list-style-type: none"> \$50 per person per calendar year \$150 per family per calendar year 	<ul style="list-style-type: none"> \$50 per person per calendar year \$150 per family per calendar year
Lifetime Orthodontics Deductible Only applies to covered orthodontic services	Not applicable – this option does not cover orthodontic services	Not applicable – this option does not cover orthodontic services	\$50 per lifetime for orthodontic services for each covered child only
Annual Maximum Benefit Applies to all covered expenses except orthodontics	Up to \$750 per calendar year for each covered person	Up to \$1500 per calendar year for each covered person	Up to \$1500 per calendar year for each covered person
Lifetime Orthodontics Maximum Benefit Only applies to covered orthodontic expenses	Not applicable – this option does not cover orthodontic services	Not applicable – this option does not cover orthodontic services	\$1,000 per lifetime for each covered child only

The percentage shown for each type of service or supply is the portion of the **allowed amount** that the Plan pays for covered expenses, up to the applicable annual and lifetime maximums.

Notes on Orthodontic Care Benefits

- They are provided only to covered children to age 26.
- The Plan generally pays one-half of its benefit when bands are placed on teeth, and one-half 12 months later, if the child is still enrolled in the Dental Plus with Orthodontics coverage option.

How the Dental Plan Works

Each time you need dental care, you may go to a participating dentist or you may go to any licensed dentist you choose (referred to as a non-participating dentist).

Regardless of the dentist used, each year you pay a portion of most dental expenses before the Plan begins to pay benefits. The amount you pay each year before benefits can begin is called your annual deductible. The annual deductible does not apply to diagnostic and preventive services.

In addition to the annual deductible, if you elect the Dental Plus with Orthodontics option, a lifetime orthodontics deductible applies for covered orthodontic services. This option's annual deductible does not apply for orthodontic services.

After you satisfy the deductible, the Plan reimburses you for a percentage of your covered expenses – up to the applicable allowed amount – and you pay the rest. The percentage you pay is called your coinsurance. Your coinsurance is based on the coverage option you choose and the type of service or supply you receive.

Maximum Plan Allowance (MPA)

The Plan pays a percentage of the applicable Maximum Plan Allowance (MPA) or the dentist's actual charge, whichever is less, as its “allowed amount” for covered expenses after you meet any required deductible. A charge is considered a MPA if:

- It is the normal charge made by the provider for a similar service or supply; and
- It does not exceed the normal charge made by most providers for the same or similar service within the same geographic area, as determined by the Claims Administrator.

The Claims Administrator determines whether a charge is a MPA.

When a Dentist Charges More Than the Allowed Amount

Your responsibility for amounts over the allowed amount depends on whether you use a participating or a non-participating dentist. It works like this.

- Participating dentists have agreed to accept pre-set fees as payment in full for covered expenses. Those fees are never more than the allowed amount, so when you use a participating dentist, you know you will not have to pay more than your deductible, coinsurance, and any amounts over the Plan's annual or lifetime maximum benefit.
- Non-participating dentists do not participate in the Plan's fee arrangement and set their own charges. Your non-participating dentist's fee for a service or supply may be higher than the Plan's allowed amount for that same service or supply. For example, if your dentist charges \$100 for a covered expense, but the MPA for that expense is \$80, your reimbursement would be based on the MPA of \$80, not the actual charge of \$100. In this case, you would be responsible for paying the \$20 difference between the MPA and the actual fee, in addition to your deductible and coinsurance.

Participating Dentists

The Plan is the Delta Dental PPO plus Premier Plan. It gives you access to two broad networks of dental providers in the Delta Dental PPO and Delta Dental Premier networks as well as the

option to use non-participating dental providers. Although you can visit any licensed dentist, you'll usually pay less when you visit a Delta Dental PPO dentist. The Delta Dental Premier network provides cost-savings features and is the next best option if you are unable to find a PPO participating dentist.

Dentists participating in the Plan's networks are located in areas convenient to Perdue locations. You may go to any participating dentist you choose. Please visit www.deltadentalins.com for a list of participating dentists in your area.

There are advantages to using a participating dentist.

- Participating dentists have agreed to accept the allowed amount for covered expenses.
- You will not have to file any claim forms since participating dentists take care of all the paperwork.

When you use a participating dentist, you are responsible for paying:

- Any required deductible;
- Required coinsurance amounts;
- Charges above your option's annual maximum benefit;
- Charges above the lifetime orthodontics maximum benefit under the Dental Plus with Orthodontics option; and
- Charges for services not covered under your option.

Non-Participating Dentists

You may select a dentist who does not participate in the Plan (referred to as a non-participating dentist), but your share of the cost of treatment may be higher. Here is how it works.

- Although the percentage of benefits available under your option remains the same for non-participating dentists, the percentage applies to the Plan's allowed amount. If your dentist's fee exceeds the allowed amount, you are responsible for paying the difference between the allowed amount and the actual fee – in addition to any required deductible and coinsurance amounts.
- Your non-participating dentist may require payment at the time of service.
- You must file a claim form to receive reimbursement for covered dental expenses.

When you use a non-participating dentist, you are responsible for paying:

- Any required deductible;
- Required coinsurance amounts;
- Charges above your option's annual maximum benefit;
- Charges above the lifetime orthodontics maximum benefit under the Dental Plus with Orthodontics option;
- Charges for services not covered under your option; and
- Any charges for covered services above the allowed amount.

Emergency Services

If you cannot use a participating dentist during a dental emergency, your benefits for covered services will be paid as if they were provided by a participating dentist. Dental emergency services are emergency examinations or emergency palliative treatment to relieve acute pain.

Documentation of the emergency nature of the services may be requested, including radiographs and/or a narrative from the treating dentist.

All other treatment you receive from the non-participating dentist will be paid as non-participating benefits.

Plan Deductibles

There are two deductibles under the Dental Plan: an **annual deductible** that applies to most covered expenses, and a **lifetime orthodontics deductible** that applies only to covered orthodontic expenses under the Dental Plus with Orthodontics option.

The amount you must pay toward your deductible is based on the coverage option you choose, as shown in this chart.

Dental Plan Coverage Options	Basic Dental	Dental Plus	Dental Plus with Orthodontics
Annual Deductible Applies to all covered expenses except preventive and diagnostic services and orthodontic services	<ul style="list-style-type: none">• \$25 per person per calendar year• \$75 per family per calendar year	<ul style="list-style-type: none">• \$50 per person per calendar year• \$150 per family per calendar year	<ul style="list-style-type: none">• \$50 per person per calendar year• \$150 per family per calendar year
Lifetime Orthodontics Deductible Applies to covered orthodontic expenses only	Not applicable – this option does not cover orthodontic services	Not applicable – this option does not cover orthodontic services	A \$50 lifetime orthodontics deductible applies to orthodontic services for each covered dependent child to age 26

Annual Deductible

The annual deductible is the amount you may be required to pay each calendar year before benefits for your covered expenses can begin. The annual deductible applies to all covered expenses except diagnostic and preventive services. If you elect the Dental Plus with Orthodontics option, covered orthodontic services also do not count toward the annual deductible.

Each option has an individual deductible and a family deductible. An individual annual deductible applies separately to each covered person. Once the family deductible is reached by any combination of you and your covered family members, the annual deductible is satisfied for all family members for the rest of the calendar year.

Expenses that Do Not Count Toward the Annual Deductible

Certain expenses do not count toward the annual deductible. These are:

- Charges for services that are not covered under your coverage option;
- Fees for covered expenses that exceed the allowed amount;
- Charges for diagnostic and preventive services; and

- Charges for covered orthodontic services under the Dental Plus with Orthodontics Option.

Lifetime Orthodontics Deductible

The Dental Plus with Orthodontics option has a \$50 lifetime orthodontics deductible that each covered dependent child must meet before benefits for covered orthodontic expenses can begin. This lifetime orthodontics deductible is applied only once during each covered child's orthodontic treatment. To see how this lifetime orthodontics deductible applies and *how and when* orthodontic benefits are paid, see the section "Orthodontics."

Expenses that Do Not Count Toward the Lifetime Orthodontics Deductible

Certain expenses do not count toward the lifetime orthodontics deductible under the Dental Plus with Orthodontics option. These are:

- Charges for orthodontic services that are not covered under the Dental Plus with Orthodontics option;
- Charges for non-orthodontic services; and
- Fees for orthodontic services that exceed the allowed amount.

Coinsurance

Coinsurance is a cost-sharing method where the Plan and covered members each pay a percentage of the cost for covered expenses. Your share of the cost is called your coinsurance. The Plan pays a percentage of the allowed amount for covered expenses and you pay the rest. If you use a non-participating dentist, you are responsible for paying your coinsurance plus any amount above the allowed amount.

Maximum Benefits

You and each of your covered dependents can receive up to a set dollar amount in benefits for covered expenses each calendar year. This is your annual maximum benefit. In addition, a separate lifetime maximum benefit applies to covered orthodontic services under the Dental Plus with Orthodontics option. No additional benefits will be paid once your benefits reach your option's maximum benefit.

Dental Plan Coverage Options	Basic Dental	Dental Plus	Dental Plus with Orthodontics
Annual Maximum Benefit Applies to all covered expenses except orthodontics	\$750 per calendar year for each covered person	\$1500 per calendar year for each covered person	\$1500 per calendar year for each covered person
Lifetime Orthodontics Maximum Benefit Only applies to covered orthodontic expenses	Not applicable – this option does not cover orthodontic services	Not applicable – this option does not cover orthodontic services	\$1,000 per lifetime for each covered dependent child up to age 26

Alternate Procedures

Often there are several ways to treat a particular dental problem and the cost of each method is different. For example, suppose in repairing your tooth, the dentist has the option of using a filling or crown, and that either treatment meets with common dental standards. In such instances, the Plan will pay covered expenses for the least expensive treatment that meets with accepted dental standards for adequate and appropriate care. If this situation occurs, and you choose to have the more expensive procedure, you are responsible for the difference between the Plan's payment and the actual charge for the procedure. This applies regardless of whether you use a participating or non-participating dentist.

You can avoid unnecessary charges by discussing treatment choices with your dentist before treatment begins. You also may ask your dentist to request a predetermination of benefits so you and your dentist know in advance what the Dental Plan will cover before treatment begins. The predetermination of benefits process is explained in greater detail in the following section.

Predetermination of Benefits

If you expect your treatment to cost more than \$300, you should have the Claims Administrator review your dentist's planned treatment and anticipated charges to determine what is covered before treatment and how much your coverage option may pay. This procedure is called predetermination of benefits. If you do not request a pre-determination of benefits, the Claims Administrator will determine the expenses that will be included as covered expenses at the time the claim is received.

Here is how the predetermination of benefits procedure works.

- Get a predetermination of benefits form from the Claims Administrator.
- Follow the instructions printed on the form.
- Give the form to your dentist to complete. Your dentist will need to describe the proposed treatment and the estimated fees.
- Submit the completed form to the address printed on the form.

You and your dentist will receive a written notice of the amount of benefits the Plan is expected to pay for the proposed treatment.

If your dentist makes a major change in the treatment plan, he or she should submit a revised plan.

Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which you or your covered dependent qualify at the time services are completed.

What the Dental Plan Covers

This section provides more details about covered expenses under the Plan. See “A Quick Look at the Options” for the level of benefits available.

Covered Expenses

To be covered by the Plan, an eligible service or supply must:

- Be performed by or under the direction of a dentist;
- Be essential for the necessary care and treatment of the teeth;
- Meet broadly accepted standards of dental practice;
- Start and finish while coverage is in effect for you or your dependent; and
- Not be excluded.

Preventive and Diagnostic Services

The Plan covers these preventive and diagnostic services – up to your option’s annual maximum benefit – without a deductible:

- Two routine oral examinations within a 12-month period*;
- Cleaning of teeth (prophylaxis) twice within a 12-month period*;
- Two topical applications of fluoride within a 12-month period* for each covered individual under age 19;
- Space maintainers for covered dependents up to age 14 (once every 60 months);
- One topical application of sealant per tooth on unfilled permanent molars for each covered individual under age 14 every 36 months;
- Bitewing X-rays twice within a 12-month period*;
- Full mouth X-rays once in any three-year period.

The plan does not require 6 months between services. **For all coverage options**, the Plan pays up to 100% of the allowed amount. You pay no deductible or coinsurance.

Basic Restorative Services

The Plan covers these basic restorative services – up to your option’s annual maximum benefit – after you meet the annual deductible:

- Amalgams (silver) and composite (white “non-molar”) fillings to restore diseased or decayed teeth.

For the Basic Dental option, the Plan pays 50% of the allowed amount. You pay the annual deductible and 50% coinsurance.

For the Dental Plus and Dental Plus with Orthodontics option, the Plan pays 80% of the allowed amount. You pay the annual deductible and 20% coinsurance.

Major Restorative Services

The Plan covers these restorative services under the Dental Plus option and the Dental Plus with Orthodontics options only – up to your option’s \$1500 annual maximum benefit – after you meet the annual deductible:

- Crowns, inlays and onlays when teeth cannot be restored with amalgam (silver) fillings; and
- Replacement of restorative crowns, inlays and onlays once only in any five-year period (regardless of who provided the previous restorative paid benefit).

For the Basic Dental option, the Plan does not pay benefits. You pay all charges.

For the Dental Plus and Dental Plus with Orthodontics options, the Plan pays 50% of the allowed amount. You pay the annual deductible and 50% coinsurance.

Oral Surgery

The Plan covers these oral surgery services — up to your option's annual maximum benefit — after you meet the annual deductible:

- Extractions;
- Oral surgery (including pre- and post-operative care); and
- General anesthesia, except with covered oral surgery procedures of one or more simple extractions and/or with surgical extractions for patients through age 18; and except with three or more simple extractions and/or surgical extractions for patients age 19 and older.

For the Basic Dental option, the Plan pays 50% of the allowed amount. You pay the annual deductible and 50% coinsurance.

For the Dental Plus and Dental Plus with Orthodontics option, the Plan pays 80% of the allowed amount. You pay the annual deductible and 20% coinsurance.

Endodontics

The Plan covers these endodontic services – up to your option's annual maximum benefit – after you meet the annual deductible:

- Pulpal therapy; and
- Root canal therapy.

For the Basic Dental option, the Plan pays 50% of the allowed amount. You pay the annual deductible and 50% coinsurance.

For the Dental Plus and Dental Plus with Orthodontics option, the Plan pays 80% of the allowed amount. You pay the annual deductible and 20% coinsurance.

Periodontics

The Plan covers these periodontic services — up to your option's annual maximum benefit — after you meet the annual deductible:

- Nonsurgical procedures for treatment of gums and supporting structures of the teeth; and
- Surgical procedures for treatment of gums and supporting structures of the teeth, provided the previous treatment was performed at least five years earlier.

For the Basic Dental option, the Plan pays 50% of the allowed amount. You pay the annual deductible and 50% coinsurance.

For the Dental Plus and Dental Plus with Orthodontics option, the Plan pays 80% of the allowed amount. You pay the annual deductible and 20% coinsurance.

Prosthodontics

The Plan covers these prosthodontic services under the Dental Plus option and the Dental Plus with Orthodontics options only – up to your option's \$1500 annual maximum benefit – after you meet the annual deductible:

- Initial installation of fixed bridges;
- Initial installation of partial or complete dentures; and
- Replacement of existing fixed bridges or partial or complete dentures once only in any five-year period (regardless of who provided the previous device or paid benefit).

For the Basic Dental option, the Plan does not pay benefits. You pay all charges.

For the Dental Plus and Dental Plus with Orthodontics options, the Plan pays 50% of the allowed amount. You pay the annual deductible and 50% coinsurance.

Orthodontics

The Plan covers these orthodontic services under the Dental Plus with Orthodontics option only – up to the \$1,000 lifetime orthodontics maximum benefit – after you meet the \$50 lifetime orthodontics deductible:

- Procedures for straightening teeth.

Orthodontic services are covered for your dependent children to age 26. Benefits for orthodontic services do not apply to your option's annual maximum benefit.

For the Dental Plus with Orthodontics option, the Plan pays 50% of the allowed amount, up to the \$1,000 lifetime orthodontics maximum benefit. You pay the \$50 lifetime orthodontics deductible and 50% coinsurance.

Generally, benefits for 50% of the full cost of orthodontics is paid when the bands are placed on the teeth. The remaining 50% of the cost is paid 12 months later, provided the patient is still covered by the Dental Plus with Orthodontics option.

When You Reach a Maximum Benefit

When your benefits from the Plan reach a maximum in your coverage option – either the annual maximum benefit or the lifetime orthodontics maximum benefit – you are responsible for all remaining charges.

What's Not Covered

Certain services, supplies or charges are not covered under the Dental Plan. Some exclusions apply to all the options and others apply to some of the options. No benefits will be paid for excluded expenses under any circumstances.

General Dental Plan Exclusions (All Options)

These services, supplies or expenses are not covered under any coverage options under the Plan:

- Charges above the Maximum Plan Allowance (MPA);
- Charges for covered expense after the applicable maximum is reached;
- Charges for which you or your dependent is in any way paid or entitled to payment for those expenses under Medicare or Medicaid (unless this exclusion is prohibited by law);
- Charges you are not legally required to pay;
- Experimental procedures or treatment methods not approved by the American Dental Association or a dental specialty society;
- General anesthesia except with covered oral surgery procedures of one or more simple extractions and/or with surgical extractions for patients through age 18, and except with three or more simple extractions and/or surgical extractions for patients age 19 and older;
- Hospitalization (including hospital visits);
- Implants;
- Increasing vertical dimension;
- Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts;
- Plaque control programs (including oral hygiene and dietary instructions);
- Prescription drugs (including topically applied medication for treatment of periodontal disease), premedications and relative analgesia;
- Procedures to correct congenital or developmental malformation (except for children eligible at birth);
- Procedures, appliances or restorations primarily for cosmetic purposes;
- Replacing tooth structure lost by attrition;
- Treatment of dysfunctions of the temporomandibular joint (TMJ); and
- Treatment provided when coverage isn't in effect (for example, before coverage begins or after it ends).

Basic Dental Option Exclusions

In addition to the general exclusions, these exclusions apply to your coverage under the Basic Dental Option:

- Major restorative services (including inlays, onlays and crowns);
- Orthodontic services (including tooth guide appliances); and
- Prosthodontic services (including bridges and dentures).

Dental Plus Option Exclusions

In addition to the general exclusions, this exclusion applies to your coverage under the Dental Plus Option:

- Orthodontic services (including tooth guide appliances).

Dental Plus and Orthodontic Option Exclusions

In addition to the general exclusions, these exclusions apply to your coverage under the Dental Plus with Orthodontics Option:

- Orthodontic services for associates and spouses; and
- Orthodontic services for your child older than age 26.

Events That May Affect Coverage

This section outlines events that may affect your coverage.

Benefit Reductions for Worker's Compensation or Liability Insurance

Services or supplies for injuries that are compensable under Workmen's Compensation, Employer's Liability insurance or Automobile Insurance (except "no fault") shall be offset against amount payable under the plan.

If You Are on an Approved Leave of Absence or Approved Disability Leave

Continuing Coverage During Your Leave

If you are on an approved leave of absence (including a leave under the Family and Medical Leave Act) or approved disability leave, your Plan coverage can continue provided you make any required contributions.

- If you are on an approved, **paid** leave (you receive compensation directly from the Company), your contributions to the Plan will continue to be deducted from your paycheck.
- If you are on an approved, **unpaid** leave (you receive either no compensation or you receive compensation from a source other than the Company, such as from a group plan or individual disability insurance policy), the arrearages for missed premium payments will be collected upon your return (or, to the extent permissible, if you do not return from leave, upon your termination).

If you choose to continue Plan coverage during your leave, but you terminate your employment or fail to return from leave and your employment is terminated, your coverage ends on the date on which your employment terminates. When coverage ends, you may be eligible to continue coverage for you and your covered dependents under COBRA (see "Continuation of Coverage Under COBRA").

Not Continuing Coverage During Your Leave

If you choose not to continue your Plan coverage during your leave, and **your leave is granted under the Family and Medical Leave Act**, you are eligible for your Plan coverage to begin when you return to active work.

If you choose not to continue your Plan coverage during your leave, and **your leave is not granted under the Family and Medical Leave Act**, you will not be eligible for your Plan coverage to begin until the next open enrollment period in which Plan coverage is offered.

Approved Leave of Absence Under Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an associate's military leave of absence. These requirements apply to coverage under the Plan for you and your eligible dependent.

Continuation of Coverage – If you are on an approved military leave of absence, your coverage under the Plan may continue, as long as you make any required premium contributions. For leaves of 31 days or more, you may continue coverage for yourself and your eligible dependent. You continue coverage by paying the required premiums to the Company, until the earliest of the following:

- 24 months from the last day of employment with the Company;
- The day after you fail to return to work; and

The date Perdue no longer offers dental benefits under the dental plan. For leaves of 31 days or more, the Company may charge you and your eligible dependents up to 102% of the total premium.

Reinstatement of Coverage – If your coverage ends during the leave of absence because you do not elect USERRA continuation coverage and you are re-employed by the Company, coverage for you and your eligible dependents under the Plan may be reinstated if:

- You gave the Company advance written or verbal notice of your military service leave; and
- The duration of all military leaves while you are employed with the Company does not exceed two years.

If your coverage under the Plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

If You Terminate Your Employment

Your coverage under the Plan ends on the day your employment terminates, whether or not your termination was due to your failure to return from a leave of absence. When coverage ends, you may be eligible to continue coverage for yourself and your eligible covered dependents under COBRA (see “Continuation of Coverage Under COBRA”).

If You Gain a New Dependent

If you gain a new dependent (for example, through marriage, birth or adoption), you may enroll your new dependent for coverage if you do so within 30 days of the date he or she becomes your eligible dependent and if you provide the Company with documentation that may be required by the Plan Administrator in order to verify the person’s status as your dependent.

If a Dependent Loses Eligibility

If a dependent no longer meets the eligibility requirements, he or she may be able to continue coverage under COBRA (see “Continuation of Coverage Under COBRA”). To continue coverage under COBRA, you or your dependent must notify your HR Department within 30 days of the date your dependent stops being an eligible dependent.

If You Die

If you die, coverage for your dependents ends. However, your eligible covered dependents may continue coverage for up to 36 months under COBRA (see “Continuation of Coverage Under COBRA”).

Claims

One of the advantages of using participating dentists under the Plan is that you do not need to submit claim forms. When you use a non-participating dentist, however, you must file a claim form to be reimbursed.

If You Use a Participating Dentist

Participating providers in the Plan's network file dental claims for you automatically. After the Claims Administrator receives a claim, it determines the benefits and sends payment directly to the participating dentist. In most cases, you'll only be billed for any applicable deductible or coinsurance amount. However, you are responsible for paying any charges that exceed your option's annual maximum benefit or the lifetime orthodontics maximum benefit under the Dental Plus with Orthodontics option, and for charges that are not covered by the Plan.

If You Use a Nonparticipating Dentist

If you use a non-participating dentist (one who does not participate in the Plan's network), you may be required to pay the provider at the time of service. You also need to submit the original, full, itemized invoice with a complete and signed claim form to request reimbursement of covered expenses.

To file for reimbursement:

- Get a claim form from <https://www.deltadentalins.com/dentists/guidance/claim-completion.html#ClaimForms>
- Follow the instructions printed on the form.
- Attach the dentist's original, full, itemized bill.
- Submit the completed form to the address printed on the form.

Your claim will be evaluated to determine if any benefits will be paid. You'll receive an explanation of benefits (EOB) statement. If benefits are payable, a check is sent to you directly from the Claims Administrator.

If your claim is denied, you may appeal the decision; see "Appealing a Claim."

Filing Deadlines

You should submit claims as soon as possible after the date the service is provided. **No benefits** will be paid for claims submitted more than 12 months after the date of service.

Urgent Care Claims

An urgent care claim is any claim for benefits with respect to which the applicable time periods for the Claims Administrator to make non-urgent care determinations could:

- Seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your health condition, would subject you to severe pain that cannot be adequately managed without the care or treatment.

If the information you supply is not enough for the Claims Administrator to decide an urgent care claim, the Claims Administrator will notify you of the deficiency and the information you need to complete the claim within 24 hours after its receipt of your claim. You must provide the requested information within a reasonable amount of time, but not more than 48 hours after the Claims Administrator notifies you of the deficiency. The Claims Administrator will then notify you of its decision within 48 hours of the earlier of its receipt of the requested information or the end of the period within which you were to provide the requested information.

Pre-Service Claim – Not Urgent

A pre-service claim (not urgent care) is any claim for a benefit under the Plan with respect to which the Claims Administrator requires you to obtain approval of the benefit in advance of receiving the care. If your claim is incomplete, the Claims Administrator will notify you of their procedures for a pre-service claim, and your failure to follow them within five days after its receipt of your deficient claim if your attempt at filing:

- Is communicated by you or your authorized representative to the Claims Administrator; and
- Names your specific health condition or symptom and a specific treatment, service or product for which approval is requested.

If the information you supply is not enough for the Claims Administrator to decide a pre-service claim, the Claims Administrator will notify you of the deficiency and the information you need to complete the claim within five days. You must provide the requested information within 45 days after the Claims Administrator notifies you of the deficiency. The Claims Administrator will then notify you of its decision within 15 days (may be extended to 30 days with notice to you).

Post-Service Claim

A post-service claim is any claim for a benefit for health care already rendered.

Concurrent Care Claims

At times, the Claims Administrator for Plan benefits may approve an ongoing course of treatment to be provided over a period of time or number of treatments.

If the Claims Administrator later reduces or no longer covers a previously approved course of treatment before the end of the approved period of time or treatments, the Claims Administrator will notify you of the adverse benefit determination sufficiently in advance of the reduction or elimination of coverage to allow you to appeal and obtain a determination before the benefit is reduced or eliminated.

If you wish to extend a course of treatment and such a claim is an urgent care claim, you should contact the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments to request extended coverage. If you adhere to this timing, the Claims Administrator will notify you of its decision within 24 hours of its receipt of your claim. If your claim is for non-urgent, concurrent care, the Claims Administrator will notify you of its decision within 15 days of its receipt of your claim. Otherwise, a decision will be issued according to the category your claim falls into at the time it is made (i.e., urgent care, pre-service or post-service). If your claim is denied, you may appeal the decision.

Decisions on Claims

You will receive a decision on your claim in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific provisions of the Plan upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

In the case of health benefits, the written denial notice also informs you of:

- Any specific rule, guideline or protocol that was relied upon or a statement that such rule, guideline or protocol was relied upon and that you may request a copy of it free of charge;
- If the adverse determination is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment or a statement that you may request such explanation free of charge; and
- In the case of an urgent care claim, a description of the expedited review process.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in the Plan Administrator's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination;
- Demonstrate compliance with the Plan Administrator's processes or safeguards; and
- In the case of health benefits, constitute a statement of the Plan Administrator's policy or guideline regarding the benefit for your diagnosis, whether relied upon or not.

Appealing a Claim

The Plan wants to be sure that you and your covered dependents and beneficiaries receive the full benefits for which you or they are eligible under each of the benefits in the Plan.

If an initial claim for benefits under the Plan is denied, in whole or in part, in an Explanation of Benefits form, a letter from a Claims Administrator or otherwise, you have 180 days to appeal the denial. Your appeal must be in writing and should contain the reasons why you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits. In the case of an urgent care claim, you may submit your request for review orally or in writing.

You will receive a decision on appeal in writing as described in the section "Decisions on Claims."

The applicable decision makers consider your request for review and notify you of their decision within the following time periods:

- Urgent care claims: 72 hours of receipt of your appeal;
- Pre-service claims: 30 days of receipt of your appeal; and
- Post-service claims: 60 days of receipt of your appeal.

Delta Dental's internal grievance procedure is described in Appendix A.

Special Rule When Decision Is Based on Medical Judgment

When a denial on appeal is based on a medical judgment, the Claims Administrator consults with a health care professional with appropriate training, who will be identified upon request. Such health care professional will be someone who was neither consulted in connection with the initial denial of a claim that is subject to the appeal, nor the subordinate of any such individual.

The final decision on appeal is sent to you in writing and will inform you of the specific reasons for the decision and the specific provision of the Plan upon which the decision is based. Except as required by law, the decisions are final and binding on all parties. You and your covered dependents must exhaust all the internal administrative remedies described above prior to bringing an action for benefits under the plans under Section 502(a) of ERISA.

Coordination of Benefits

The Plan has a coordination of benefits (COB) provision. This feature is designed to prevent duplicate benefit payments when you or your eligible dependent participate in more than one group plan.

The Primary Plan Determines Benefits First

Under the COB provision, the Claims Administrator determines that one plan is primary and determines its benefits first. Any other plan is secondary. To claim benefits, submit your claim to the primary plan first. After that plan determines its benefits, submit a claim to the secondary plan(s) along with a copy of the explanation of benefits (EOB) statement you received from the primary plan. The secondary plan(s) will then determine if any additional benefits are payable.

- If this Plan is the primary plan, it pays its benefits without regard to the secondary plan.
- If this Plan is secondary, it coordinates benefits with the primary plan(s).

Here's how this works. The Claims Administrator first calculates what the Plan would have paid if it were the primary plan. Second, the Claims Administrator reviews the explanation of benefits (EOB) statement you receive from the primary plan to determine what the primary plan paid. The Plan then pays the lesser of the difference between the primary plan's payment, up to the amount the Dental Plan would have paid if it were the primary plan or the amount of the remaining expenses. In no instance will the Plan pay more than it would have paid if it was the primary plan.

How the Claims Administrator Determines Which Plan Is Primary

The Claims Administrator determines which plan is primary and which plan(s) is secondary under the following rules:

- The plan covering a person as an associate is primary, and the plan covering the person as a dependent is secondary.

For dependent children, determination of the primary and secondary plan(s) follows these rules in this sequence:

- The "birthday" rule. The plan covering the parent whose birthday (month and day) comes first in the year is the primary plan for the children, and the plan covering the other parent is the secondary plan for the children. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- If the parents of dependent children are divorced or legally separated, and there is a court decree establishing financial responsibility for health care, then the plan of the parent named by the court as responsible for health care will be the primary plan.
- If there is no such decree, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary.

- If there is no such decree and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan is secondary, and the noncustodial parent's plan is third.
- The program covering the enrollee as an Employee or as a dependent of an Employee will determine its benefits before one that covers the enrollee as a laid-off or retired Employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired Employee, and as a result each plan determines its benefits after the other, then this paragraph will not apply.
- If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary," Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.
- If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan.

When Coverage Ends

This section outlines when coverage ends. When coverage ends, you may be able to continue coverage for a limited period of time under COBRA.

When Associate Coverage Ends

Your coverage ends on the earliest date one of the following events occur:

- The day you stop working for the Company for any reason;
- You are no longer an eligible associate;
- The Plan is terminated;
- You elect to terminate coverage under the Plan due to a qualified status change or other event permitting an election change; or
- You fail to pay any required premiums.

When your coverage ends, you may be able to continue Plan coverage under COBRA.

When Dependent Coverage Ends

In most cases, dependent coverage ends on the date your coverage ends. It also ends on the earliest date one of the following events occur:

- The first day your covered dependent is no longer eligible; or
- You fail to pay any required premiums.

You *must* notify your HR Department within 30 days of the date that your dependent no longer qualifies as an eligible dependent. Information about continuing coverage under COBRA will be sent to your dependent.

Continuing Coverage

When coverage ends for you and/or a covered dependent, you may have an opportunity to continue coverage beyond the time it would otherwise end.

Continuation of Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your eligible dependent(s) may be eligible to continue health coverage if you or your eligible dependents) coverage ends because of certain “qualifying events.” The following information outlines the continuation of coverage available under COBRA.

COBRA requires most employers who sponsor group health care plans to provide a temporary extension of coverage to associates and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer’s plan. Under COBRA, you (or your dependents) will generally be permitted to continue the same coverage that you (or your dependents) had prior to the event that would otherwise cause the loss of coverage. This temporary extension of benefits is commonly called “continuation coverage.”

Here is a summary of who is eligible for continuation coverage under COBRA, when they become eligible, and for how long the coverage may continue:

These People	May continue coverage if it is lost due to...	For up to...
Associate	<ul style="list-style-type: none">• Reduction in associate's hours of employment• Termination of associate's employment for any reason other than gross misconduct• Failure to return from a leave of absence under the Family and Medical Leave Act of 1993	<ul style="list-style-type: none">• 18 months• 18 months• 18 months
Covered spouse of an associate	<ul style="list-style-type: none">• Reduction in associate's hours of employment• Termination of associate's employment for any reason other than gross misconduct• Associate's failure to return from a leave of absence under the Family and Medical Leave Act of 1993• Death of associate• Divorce or legal separation• Associate becomes entitled to Medicare and elects Medicare as primary provider	<ul style="list-style-type: none">• 18 months• 18 months• 18 months• 36 months• 36 months• 36 months

These People	May continue coverage if it is lost due to...	For up to...
Covered dependent child(ren) of an associate	• Reduction in associate's hours of employment	• 18 months
	• Termination of associate's employment for any reason other than gross misconduct	• 18 months
	• Associate's failure to return from a leave of absence under the Family and Medical Leave Act of 1993	• 18 months
	• Death of associate	• 36 months
	• Associate divorce or legal separation	• 36 months
	• Associate becomes entitled to Medicare and elects Medicare as primary provider	• 36 months
	• Loss of dependent status under the Plan	• 36 months

When COBRA Coverage May Continue Beyond 18 Months

If a covered person has an 18-month qualifying event and the Social Security Administration determines that person to be disabled at any time during the first 60 days of continued COBRA coverage, coverage for you and your dependents may be extended from 18 months to 29 months.

- If the disabled person recovers and is no longer disabled, you must notify the COBRA Administrator within 30 days, and COBRA coverage may be continued only for the remainder of the original 18-month period.
- If the disabled person recovers after the end of the original 18-month period, COBRA coverage will end on the last day of the month in which the person is no longer disabled.

If during an 18-month continuation period a second qualifying event occurs that entitles your dependent to COBRA coverage, your dependent's coverage may be extended by another 18 months. You must notify the COBRA Administrator within 60 days of the second qualifying event. But in no case will COBRA coverage continue for more than 36 months from the first qualifying event.

The 18, 29 or 36 months of continuation coverage begins on the date of the event that causes loss of coverage.

Qualified Beneficiaries

Individuals who are eligible for COBRA coverage are called "qualified beneficiaries." The events that entitle them to coverage are called "qualifying events." Generally, to be a qualified beneficiary, you must have health coverage under the Plan on the day before a qualifying event occurs; however, a child born to, adopted by or placed for adoption with you during the continuation coverage period is also a "qualified beneficiary."

Loss of Coverage

When a qualifying event occurs, you and the Company have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, you or your eligible dependent must notify the COBRA Administrator in writing within 60 days of the qualifying event. The COBRA Administrator will know if the event is death, termination of employment, reduction in hours, failure to return from a leave of absence under the Family and Medical Leave Act of 1993, entitlement to Medicare benefits or the commencement of a bankruptcy proceeding.

When the COBRA Administrator is notified or learns of a qualifying event, the Plan Administrator will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You then have 60 days from the later of the date of this explanation or the date on which your existing coverage would end to notify the COBRA Administrator of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

COBRA Election

Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one eligible dependent may make an election that covers some or all of the others.

If you elect to continue coverage:

- *You must pay a total premium equal to the group rate plus a 2% administration charge monthly (or such higher charge as may be permitted by law)*.*
- The total premium includes the contribution an active participant must make under the Plan.
- The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for months after your election must be paid within 30 days of the date due. Premium rates may change periodically for all qualified beneficiaries.

The coverage provided will be identical to the coverage provided similarly-situated associates or dependents. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

* If you or your covered dependent is eligible for the additional 11 months of coverage because of disability, the premium for the additional 11 months is increased to 150% of the group rate. This increased premium may also apply through the 36th month if a second qualifying event later extends the continuation period to 36 months.

Benefits for Eligible Dependents

Unless otherwise specified in the election, any election of continuation coverage made by you or your spouse or former spouse will be considered to be an election of continuation coverage for any eligible dependent who would also lose coverage by reason of the qualifying event. If you elect continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of benefits until the next open enrollment period. At that time, they may change their coverage if they wish.

However, if you decide not to continue your coverage at all, or if you elect to continue coverage just for yourself (and not for your dependents), then each eligible dependent may make an independent benefit selection.

Changes to Continuation Coverage

Qualified beneficiaries have the same opportunities to change coverage as active associates during the annual open enrollment period. During open enrollment, you may elect different coverage or add or delete dependents, as if you were an active associate.

When COBRA Benefits End

Generally, continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart earlier in this section. However, COBRA benefits will end immediately if:

- The person whose coverage is being continued fails to pay the premium on time;
- The person whose coverage is being continued becomes covered under another employer's group health plan, unless the other group health plan contains an exclusion or limitation with respect to a pre-existing condition of the person (other than an exclusion or limitation which does not apply to [or is satisfied by] the person under applicable provisions of federal law);
- The person whose coverage is being continued becomes entitled to Medicare benefits (this does not apply if you are entitled to purchase continuation coverage due to commencement of a bankruptcy proceeding by the Company);
- In the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the person is no longer disabled under the Social Security laws*; or
- The Company no longer maintains a group health plan covering any associate.

* A qualified beneficiary is responsible for notifying the COBRA Administrator within 30 days of the date of a final determination that he or she is no longer disabled under the Social Security laws.

Two Qualifying Events

An 18-month or 29-month period of continuation coverage may be extended if another qualifying event (other than a bankruptcy proceeding) occurs during that time. However, no one may extend coverage for more than 36 months. The 36-month period is counted from the first event. For example, if your employment ends and you get divorced during the 18-month continuation period for which you have elected continuation coverage for you and your dependents, your dependents may extend coverage for up to 36 months from the date your employment ended. In addition, if you become entitled to Medicare benefits and during the subsequent 18-month period lose coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than you will be entitled to a maximum of 36 months of coverage from the date of your Medicare entitlement, subject to the rules regarding earlier termination of COBRA continuation coverage. You remain entitled to 18 months of continuation coverage from the date of your termination of employment or a reduction in hours of employment. To qualify for this extension, you must notify the COBRA Administrator in writing within 60 days of the event.

Converting Coverage to an Individual Policy

This option is not available under the Plan.

Your Rights Under ERISA

This section contains administrative information about the Plan and other details required under the terms of a federal law, the Employee Retirement Income Security Act of 1974, as amended (ERISA).

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to the following rights.

Right to Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue Plan coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union (if applicable) or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials

were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Important Information

Plan Costs

The Plan is self-insured. Delta Dental of Pennsylvania (“Delta Dental”) serves as a third party administrator. You pay the full cost of any coverage you elect.

No Right to Employment

This SPD and the benefits it describes are not a contract of employment between the Company and any associate. As an “at-will employee,” either the Company or you may terminate your employment at any time, with or without notice, and with or without cause.

Plan Documents Govern

This summary plan description was designed to describe the key features of the Plan in easy-to-understand terms. However, it is the plan documents that determine your rights and the rights of your dependents under the Plan. In the event of a discrepancy between this summary plan description and the plan documents, the plan documents will govern.

No person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company or which alters the Plan or plan documents maintained in conjunction with the Plan.

Effect of Third Parties on Your Benefits

If benefits are payable or have been paid by the Plan as a result of an action by a third party or organization (for example, a claim resulting from an injury suffered in an accident caused by another person), the Plan will be “subrogated” to the right of you, your covered dependent or a beneficiary to recover from the third party or organization. This means any judgment received from the third party or organization may be paid to the Plan to recover the benefit paid to you, your covered dependent or a beneficiary.

If the Plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the Plan has the discretion whether to pay benefits. Also, the Plan has the discretion to exercise only its right of receiving reimbursement.

If you, your covered dependent or a beneficiary – or a third party on your behalf – consider initiating an action against a third party or organization, contact the Plan Administrator before you begin any type of action against a third party or organization regarding the third party’s or organization’s involvement in the incident that resulted in your loss.

Excess Payments

If the Plan Administrator, or its designated representative, has made an erroneous or excess payment to you or on your behalf, the Plan Administrator will be entitled to take such action as the Plan Administrator deems necessary and equitable to correct such error, including recovering such excess from you. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable to you or on your behalf by the amount of the overpayment under, to the extent permitted by applicable law.

Limits on Assignment of Benefits

To the extent permitted by law, and except where specified under the terms of the Plan, no benefits will be subject to assignment, alienation, sale, transfer, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. However, your benefits may be subject to a Qualified Medical Child Support Order.

Plan May Be Amended or Terminated

The Company expects to continue the Plan, but reserves the right to amend or terminate the Plan at any time (subject to the terms of the plan documents). In addition, the Company does not guarantee the continuation of any Plan benefits during employment or at the commencement of or during retirement, nor does it guarantee any specific level of benefits or contributions.

Plan Administrator and Claims Administrator

The Plan Administrator and the Claims Administrator have the full discretionary authority and power to control and manage all aspects of the Plan, to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements and to adopt rules for the administration of the Plan as they may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or render advice with respect to its responsibilities under the Plan including discretionary authority to interpret and construe the terms of the Plan, to direct payment of benefits, and to determine eligibility for Plan benefits.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan to be void, unlawful, or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in force and effect.

Applicable Law

The Plan shall be governed and construed in accordance with the laws of the State of Maryland, to the extent not pre-empted by the laws of the United States.

Dental Plan Identification

Plan Name	The official Plan name is the Perdue Farms Inc. Dental Plan.	
Plan Sponsor	The Plan Sponsor is Perdue Farms Inc.	
Type of Administration	The benefits under the Plan are administered under a third-party administrator, Delta Dental of Pennsylvania.	
Plan Administrator	The Plan Administrator is: The Perdue Benefits Committee 31149 Old Ocean City Road Salisbury, MD 21804 1-410-543-3000	
Claims Administrator	The Claims Administrator for benefits under the Perdue Farms Inc. Dental Plan is: Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, Pennsylvania 17055 1-800-932-0783	
Claims Fiduciary for Eligibility	The Claims Fiduciary for determining eligibility for coverage under the Perdue Farms Inc. Dental Plan is: The Perdue Benefits Committee Perdue Farms Inc. 31149 Old Ocean City Road Salisbury, MD21804	
COBRA Administrator	Before July 1, 2018 ConnectYourCare 307 International Cir. #200 Cockeysville, MD 21030 1-410-891-1000	As of July 1, 2018 CareFirst Administrators 3060 Williams Drive, Suite 200 Fairfax, VA 22031 877-889-2478
Agent for Service of Legal Process	Legal process may be made on the Plan Administrator.	
Plan Records and Plan Year	The Perdue Farms Inc. Dental Plan and all of its records are maintained on a calendar year basis, beginning on January 1 and ending on December 31 of each year.	
Type of Plan	The Perdue Farms Inc. Dental Plan, which is a component of the Perdue Farms Inc. Welfare Benefit Plan, is considered a welfare plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA).	
Plan Number	The Plan Number is 502	
Employer Identification Number	The Employer Identification Number of the Plan Sponsor is 52-0888853.	

PERDUE FARMS INC. WELFARE BENEFIT PLAN

Plan Document and Summary Plan Description

Amended and Restated Effective January 1, 2019

This document, together with the attached documents, constitutes the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102 for the Perdue Farms Inc. Welfare Benefit Plan. If you have any difficulty understanding any part of this document, you should contact your Human Resources Department for assistance.

El Manual contiene un sumario en Inglés de sus derechos y beneficios bajo los planes que le son aplicables. Si usted tiene alguna dificultad en entender cualquier parte del Manual, usted deberá contactar a su Departamento de Recursos Humanos para que lo asista.

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ARTICLE I

INTRODUCTION

THIS INSTRUMENT made and published by Perdue Farms Inc. (the “Company”) constitutes the Perdue Farms Inc. Welfare Benefit Plan (the “Plan”) and Summary Plan Description (“SPD”) amended and restated effective January 1, 2019 for the benefit of its eligible employees. The Plan is referred to as a “wrap plan,” because it takes different benefits offered by the Company and wraps them into this unified and bundled plan.

The Company previously established several employee welfare benefit plans within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). These have been wrapped into this Plan and are now called “Component Benefit Programs.” Each Component Benefit Program and the documents governing it are hereby incorporated by reference.

All of the benefits under the Plan are offered under a particular Component Benefit Program and are determined exclusively by the terms of the Component Benefit Programs and, to the extent that a benefit is insured, the insurance contract. The terms of such Component Benefit Programs have been set forth in various benefit schedules, booklets, insurance policies, service contracts and other documents as amended from time to time. Refer to these relevant documents for the Component Benefit Program’s benefit eligibility, plan provisions and benefits, termination and continuation provisions, contribution and claims procedure information.

Taken together, this document and the documents related to each Component Benefit Program, as each document may be amended or replaced from time to time, are the official Plan document and SPD required by ERISA.

ARTICLE II

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan document and SPD, unless a different meaning is plainly required by the context.

- 2.01. "Associate"** means any salaried or hourly individual whose position requires him or her to work at least 30 regularly scheduled hours a week for the Employer and who is in Benefit Group 1, 2, 3 or 4, as determined by the Employer. Notwithstanding the foregoing, the term "Associate" does not include any of the following: (a) leased employee; (b) individuals classified by the Employer as a contract worker, independent contractor, or temporary employee, whether or not such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; or (c) individuals performing services for the Employer, but paid by a temporary staffing agency for the period during which such individual is paid by such agency, whether or not the individual is determined by the IRS or others to be a common-law employee of the Employer.
- 2.02. "Board of Directors"** means the Board of Directors of the Company.
- 2.03. "Code"** means the Internal Revenue Code of 1986, as amended from time to time.
- 2.04. "Company"** means Perdue Farms Inc. and any successor entity.
- 2.05. "Component Benefit Program"** means one of the programs listed on Appendix A. The Component Benefit Programs are specifically incorporated in the Plan by reference. Appendix A may be revised from time to time as necessary without formal amendment to this Plan.
- 2.06. "Component SPD"** means, for each Component Benefit Program, the benefit schedule, booklet, insurance policy, service contract and other documents associated with the Component Benefit Program. The Component SPDs are specifically incorporated into the Plan by reference.
- 2.07. "Covered Component"** means each Component Benefit Program that, if it were a separate employee benefit plan, would be a "Covered Entity" within the meaning of HIPAA.
- 2.08. "Dependent"** means any individual who is a dependent of a Participant within the meaning of Code Section 152, with the following exception. For purposes of accident or health coverage, a dependent is determined without regard to Sections 152(b)(1), 152(b)(2) and 152(d)(1)(B) of the Code; and, further includes any child (as defined in Section 152(f)(1) of the Code) of a Participant who, as of the end of the taxable year, has not attained age 27. Any child to whom Section 152(e) of the Code applies shall be treated as a Dependent of both parents for purposes of accident and health coverage.

- 2.09. **“Employer”** means Perdue Farms Inc., or any affiliate or subsidiary corporation that adopts this Plan with the consent of the Company and is listed on Appendix D, which may be amended from time to time without a formal amendment to the Plan.
- 2.10. **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
- 2.11. **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
- 2.12. **“Insurer”** means any insurance company, health maintenance organization, or other company with which the Company has entered into a contract to provide Plan services or benefits.
- 2.13. **“Open Enrollment”** shall mean a period of at least ten consecutive working days in each Plan Year during which Associates may select among the options for coverage under the Plan.
- 2.14. **“Participant”** means any Associate who has met the eligibility requirements set forth in the Plan, and who, in a timely manner, has enrolled and made all contributions required under the Plan.
- 2.15. **“Plan Administrator”** means the Perdue Farms, Inc. Benefits Committee.
- 2.16. **“Plan Year”** means the calendar year.
- 2.17. **“Spouse”** means an individual who is legally married to a Participant. A Spouse, however, does not include an individual separated from the Participant under a legal separation decree.

ARTICLE III
PARTICIPATION, BENEFITS AND CONTRIBUTIONS

3.01. Participation.

The eligibility rules for each Component Benefit Program are described in the applicable Component SPD. Eligibility requirements may vary by type of coverage. The rules for termination of coverage are also set forth in the Component SPDs.

3.02. Benefits.

The benefits provided under this Plan are described in detail in Component SPDs.

3.03. Contributions.

Associates may be required to pay all or a portion of the costs for a particular coverage as set forth each year by the Plan Administrator. The Company provides a schedule of applicable premiums for benefits under each Component Benefits Program during the initial enrollment period, later Open Enrollment periods, and on request.

ARTICLE IV

PLAN ADMINISTRATION

4.01. Allocation of Authority.

Except as to those functions reserved by the Company, the Plan Administrator shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right and discretion:

- (a) To interpret this Plan and SPD, the Component SPDs, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions; and
- (b) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the Plan shall be conclusive and binding on all persons. Any interpretation or determination made pursuant to the Plan Administrator's discretionary authority shall be upheld on review unless it is shown that the interpretation or determination was an abuse of discretion (*i.e.*, arbitrary and capricious).

4.02. Powers and Duties of Plan Administrator.

The Plan Administrator shall have the following powers and duties:

- (a) To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan;
- (b) To make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator shall deem necessary for the efficient administration of the Plan;
- (c) To decide on questions concerning the Plan and the eligibility of any Associate to participate in the Plan, in accordance with the provisions of the Plan;
- (d) To determine the amount of benefits that shall be payable to any person in accordance with the provisions of the Plan; to inform the Company, as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part; and
- (e) To designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan; and to retain such actuaries, accountants (including Associates who are

actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration.

4.03. Delegation by the Plan Administrator.

The Plan Administrator may employ the services of any such persons (including an Insurer) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan.

Such right shall include the power to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as medical necessity or experimental treatments.

The Plan Administrator, the Company, and any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Associates who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Company, or such delegate shall be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

4.04. Several Fiduciary Liabilities.

To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for his own willful misconduct or willful breach of this Plan.

4.05. Indemnification and Exculpation.

To the extent permitted by law, the Plan Administrator, its agents, and officers, directors, and Associates of the Company shall be indemnified and held harmless by the Company against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Company's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this section shall not be applicable to any person if the loss, cost, liability, or expense is due to the person's gross negligence or willful misconduct.

4.06. Compensation of Plan Administrator.

Members of the Perdue Farms, Inc. Benefits Committee will serve at the pleasure of the Board of Directors, without compensation, unless otherwise determined by the Board of Directors.

4.07. Bonding.

Unless required by ERISA, by the Board of Directors, or by any other federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates shall be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

ARTICLE V
AMENDMENT AND TERMINATION OF PLAN

5.01. Amendment.

The Company shall have the right to amend this Plan in any and all respects at any time. Any such amendment may be made by formal action of the Plan Administrator; provided, however, that only the Board of Directors may authorize an amendment to the Plan that materially increases the duties and liabilities of the Company.

5.02. Termination of Plan.

Regardless of any other provision of this Plan, the Company necessarily reserves the right to terminate this Plan with respect to any and all Participants, Spouses, and Dependents at any time without prior notice. Such termination shall be evidenced by a written resolution of a majority of the Board of Directors, a certified copy of which shall be filed with the Plan Administrator, the Board of Directors, and any outside provider of plan administration services.

5.03. Termination by Dissolution, Insolvency, Bankruptcy, Merger, Etc.

This Plan shall automatically terminate if the Company (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Participants.

5.04 Adoption by Additional Employers.

Any affiliate or subsidiary of the Company may adopt this Plan by a resolution of the Plan Administrator or other governing body, as well as by formal action by the Plan Administrator indicating the fact and approval of the adoption.

ARTICLE VI

BENEFIT FUNDING

6.01. No Trust Required.

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific benefit, but shall instead be considered general assets of Company. Nothing herein shall be construed as requiring Company, any Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no eligible Associate or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of Company (or any Employer) from which any payment under the Plan is made.

6.02. Company Funding.

Benefits provided under this Plan may be paid in cash from the general assets of the Company. No Associates shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Company may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Company and an Associate or any other person. Neither an Associate nor a beneficiary of an Associate shall acquire any interest greater than that of an unsecured creditor.

6.03. Funding Policy.

The Company shall have the right to enter into a contract with one or more Insurers for the purposes of (1) providing any benefits under the Plan or (2) indemnifying the Plan and Trust against specific and/or aggregate losses. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract, to the extent allocable to contributions made by the Company, shall not be assets of the Plan but shall be the property of, and shall be retained by, the Company.

ARTICLE VII

HIPAA PRIVACY AND SECURITY RULES

7.01. Generally.

This Plan is a “hybrid entity” within the meaning of HIPAA. This Plan elects to provide the privacy and security protections required by HIPAA only to the Covered Components. Each Covered Component is subject to HIPAA’s privacy and security rules, which are codified at 45 Code of Federal Regulations Parts 160 and 164, Subparts A and E (the “Privacy and Security Rules”). The Privacy and Security Rules require covered group health plans to preserve the confidentiality of protected health information, or “PHI.” PHI is health information that can be linked to a specific individual as defined in 45 CFR Section 160.103. It includes, for example, information about the health care received by an individual and the amount paid for such care. All capitalized terms that are used in this Article VII that are not otherwise defined by the provisions of the Plan or this paragraph shall have the same meaning as given under HIPAA and the Privacy and Security Rules.

7.02. Privacy Rule.

As described in the Notice of Privacy Practices for each Covered Component, the Company will not use or disclose PHI, except as necessary to administer such Covered Component (including performing treatment, payment and health care operations) and any organized health care arrangement that may be established by the Company, or as otherwise permitted or required by law. With regard to any Covered Component that is a self-insured group health plan that is subject to HIPAA, the Company agrees it will:

- (a) Not use or further disclose PHI other than as permitted or required by such Covered Component and the Privacy and Security Rules.
- (b) Ensure that any agent, subcontractor, or other party with whom it shares PHI will agree to the same, or substantially similar, restrictions and conditions that apply to the Company with respect to PHI. To be considered substantially similar, those restrictions and conditions must meet the requirements of the Privacy and Security Rules.
- (c) Not use or disclose the PHI of any Associate for employment-related actions and decisions or in connection with any non-Covered Component or any other benefit plan of the Company.
- (d) Report to the Covered Component any use or disclosure of PHI that it becomes aware of that is inconsistent with the Privacy and Security Rules or such Covered Component’s Notice of Privacy Practices.
- (e) Make available to each individual covered under the Covered Component his PHI so that he or she may exercise his rights under HIPAA, including seeing and copying his PHI, receiving an accounting of certain of its disclosures and, under certain

circumstances, amending the information. These rights are more fully explained in the Notice of Privacy Practices for such Covered Component.

- (f) Make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from such Covered Component available to the Secretary of the U.S. Department of Health and Human Services, charged with the enforcement of the Privacy and Security Rules, for purposes of determining compliance with the Privacy and Security Rules. Providing this information to the Secretary will not waive any attorney-client, accountant-client, or other legal privilege or the work product rule.
- (g) If feasible, return or destroy all PHI received from such Covered Component when it is no longer needed. If this is not possible, the Company will limit further uses and disclosures of it to those purposes that meet the requirements of the Privacy and Security Rules and that make the return or destruction of the information infeasible.
- (h) Ensure that there is adequate separation between the functions Associates perform on behalf of the Company, the functions the Plan Administrator performs in administering the Covered Component and this Plan, and the employer functions of the Company.

The Plan Administrator administers the Plan and each Component Benefit Program. Certain Associates who perform plan administrative functions on behalf of the Plan Administrator are given access to PHI, and may only use and disclose PHI for plan administration purposes. Any Associate who uses or discloses PHI for a purpose other than plan administration or as permitted or required by law will be subject to disciplinary action and sanctions, up to and including termination, in accordance with the Company's policies. The Company will arrange to maintain records of such violations, as well as disciplinary and corrective measures taken with respect to each incident.

7.03. Security Rule.

As a condition for obtaining Electronic Protected Health Information ("Electronic PHI") from the Plan or any Covered Component that is self-insured, the Company agrees that it will:

- (a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of each Covered Component.
- (b) Ensure that adequate separation between each Covered Component and the Company, as required by 45 CFR Section 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

- (c) Ensure that any agent, subcontractor and other party to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.
- (d) Report to the applicable Covered Component any Security Incident of which it becomes aware.

7.04. Exceptions.

Notwithstanding any other provision of the Article VII to the contrary, this Article VII and the Privacy and Security Rules do not apply to the following:

- (a) Information about whether an individual is participating in the Plan or any Covered Component; and
- (b) Summary Health Information, provided that the Company requests Summary Health Information for the purpose of obtaining premium bids providing insurance coverage under the Plan or any Component Benefit Program; or modifying, amending or terminating the Plan or any Component Benefit Program, all as permitted by the Privacy and Security Rules.

Questions about the Privacy and Security Rules or about the Notice of Privacy Practices issued by each Component Benefit Program that is a group health plan subject to HIPAA can be directed to the Plan Administrator.

ARTICLE VIII

MISCELLANEOUS

8.01. Exclusive Benefit.

Except as otherwise permitted by law, the Plan shall be maintained for the exclusive benefit of the eligible Associates who participate in the Plan and their Spouses and Dependents.

8.02. Written Communications.

All communications in connection with the Plan made by an eligible Associate or his or her Spouse or Dependents shall become effective only when such communications have been duly executed by the eligible Associate (or other appropriate person) and received by the Plan Administrator (or its designee).

8.03. Company Protective Clause.

No Participant, Spouse, or Dependent shall have any vested or nonforfeitable right to any benefit by reason of participation herein.

8.04. No Guarantee of Tax Consequences.

Although the Company intends to permit a Participant to pay for certain benefits under this Plan on a pre-tax basis through the Perdue Farms Inc. Premium Conversion Plan, neither the Plan Administrator, the Company (or any Employer) guarantees that any amount paid to or for the benefit of a Participant pursuant to this Plan will be excludable from the Participant's gross income for federal, state, or other tax purposes, or that any other tax treatment of such amounts will apply to or be available to any Participant.

8.05. In General.

Any and all rights accruing to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Company and any Participant, Spouse, or Dependent, nor shall it be consideration or an inducement for the initial or continued employment of any Associate. Likewise, maintenance of this Plan shall not be construed to give any Participant the right to be retained as an Associate by the Company or the right to any benefits not specifically provided by the Plan.

8.06. Waiver and Estoppel.

No term, condition, or provision of this Plan shall be deemed to waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant, Spouse, or Dependent other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

8.07 Effect on Other Benefit Plans.

Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of a tax-qualified retirement plan maintained by the Company or a participating affiliate or subsidiary (unless otherwise provided under the terms of any such plan). The treatment of amounts paid under this Plan under other employee benefit plans shall be determined under the provisions of the applicable employee benefit plan.

8.08. Nonvested Benefits.

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Participant or Eligible Dependent except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plan terms in effect when the expense is incurred.

8.09. Interests Not Transferable.

The interests of the Participants and their Dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered without the written consent of the Plan Administrator.

8.10. Gender and Number.

Except when otherwise indicated by the context, words in the masculine gender shall include the feminine and neuter genders, the plural shall include the singular, and the singular shall include the plural.

8.11. Severability.

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Company shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

8.12. Headings.

All article and section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

8.13. Applicable Law.

This Plan is fully exempt from Titles II, III, and IV of ERISA. The Plan shall be governed and construed in accordance with Title I of ERISA and the laws of the State of Maryland to the extent not preempted by ERISA.

8.14. Correction of Errors.

Notwithstanding anything to the contrary contained in the Plan, the Plan Administrator or its delegate is expressly empowered to correct any errors in the administration of the Plan. Any such correction may be made retroactively.

8.15 SPDs Superseded.

This Plan document, and the attachments hereto, supersede any other summary plan descriptions for the Plan. This Plan document will generally control and prevail in the event of any discrepancies or differences in interpretation between the terms, conditions or language in this Plan document, and in the terms, conditions or language contained in any other documents that comprise part of a Component Benefit Program or in any of its agents in connection with the administration of the Plan or any of the Component Benefit Programs.

ARTICLE IX
GENERAL INFORMATION ABOUT THE PLAN

Plan Name: Perdue Farms Inc. Welfare Benefit Plan

Plan Sponsor: Perdue Farms Inc.
P.O. Box 1537
Salisbury, MD 21802-1537
Telephone: 410-543-3000

EIN: 52-0888853

Plan Number: 502

Named Fiduciary: For purposes of ERISA Section 402(a), the Named Fiduciary is the Perdue Farms, Inc. Benefits Committee.

Type of Plan: The Plan is a welfare benefit plan providing medical, dental, vision, life insurance, short-term disability, long-term disability, accidental death and disability, business travel accident, employee assistance, and health care flexible spending account benefits.

Type of Administration: This Plan is administered by the Company, except that one or more Insurers may administer portions of the Plan governed by insurance contracts. The Company may also contract with one or more service providers to assist in the administration of part or all of the Plan or any Component Benefit Program.

Plan Administration: For purposes of ERISA Section 3(16), the Plan Administrator is the Perdue Farms, Inc. Benefits Committee.

Agent for Service of Legal Process: Service for legal process may be made upon the Plan Administrator.

**Source of
Contributions:**

The contributions for any fully-insured benefits (insurance premiums) or self-insured benefit shall be made by the Company out of its general assets and/or by Associates, in such amounts or proportions as the Company may determine, in its sole and unfettered discretion, from time to time.

The Company will provide a schedule of contributions for benefits under each Component Benefit Program during the initial and Open Enrollment periods, and on request.

Funding Medium:

To the extent that benefits under a Component Benefit Program are fully-insured, the Insurer (and not the Company) is responsible for paying claims for benefits under that Component Benefit Program.

To the extent that benefits under a Component Benefit Program that are self-insured, the Company is responsible for paying claims for benefits under that Component Benefit Program. The Company will make such payments out of the general assets of the Company.

Participant benefit accounts under the Plan, if any, are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. No assets shall be segregated for the purpose of providing benefits under the Plan.

ARTICLE X

STATEMENT OF ERISA RIGHTS

10.01. Receive Information About the Plan and Benefits.

Covered Persons have the right to:

- (a) Examine, without charge, at the Plan Administrator's office, all plan documents, including Insurance Contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- (b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any Insurance Contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

10.02. Continue Group Health Plan Coverage.

A Covered Participant, Spouse, or Child has the right to continue health care coverage, if there is a loss of coverage under the Plan as a result of a qualifying event. Each Covered Person will have to pay for such coverage. Further details about the rules governing COBRA continuation coverage rights can be found in the Component SPDs.

10.03. Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants and beneficiaries. No one, including the Company, an Employer, or any other person, may fire a Covered Person or otherwise discriminate against him in any way to prevent him from obtaining a welfare benefit or exercising his rights under ERISA.

10.04. Enforcement of Rights.

If a Covered Person's claim for a welfare benefit is denied or ignored, in whole or in part, the Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that can be taken to enforce the above rights. For instance, if the Covered Person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until the materials are received, unless the materials were not sent because

of reasons beyond the control of the administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or federal court. In addition, if the Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his rights, the Covered Person may seek assistance from the U.S. Department of Labor, or he may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the persons sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the claim is frivolous.

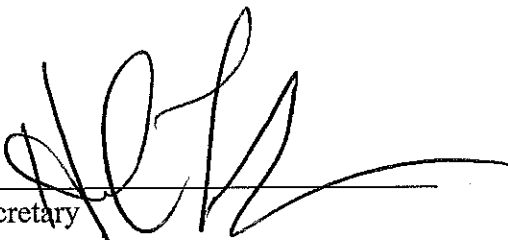
10.05. Assistance With Questions.

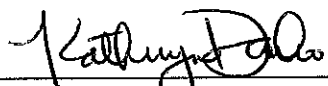
If a Covered Person has questions about this Plan, he should contact the Plan Administrator. If a Covered Person has any questions about this statement or about his rights under ERISA, or if a Covered Person needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in a telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The Covered Person may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IN WITNESS WHEREOF, Perdue Farms Inc. has caused this Plan to be executed by its duly authorized officer as of the date first written above.

ATTEST:

Perdue Farms Inc.


Secretary

By: 
Kathryn Danko
Vice President, Human Resources Services
& Chief Diversity and Inclusion
Officer

[SEAL]

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APPENDIX A

Component Benefit Programs

The benefits provided under the Plan shall be those fully-insured and self-insured benefits as shall be made available to eligible Associates from time to time, as such benefits may be amended or terminated in the future. The terms, conditions and limitations of the benefits are set forth in the Plan and in the Component Benefit Programs that are incorporated into the Plan. Certain documents are incorporated by reference in this Appendix A, including any written document pursuant to which the applicable Benefit is provided under the Plan (e.g., written plans, vendor contracts, insurance policies, coverage certificates, Component SPDs, or other materials describing Benefits offered under the Component Benefit Programs). This Appendix is considered a part of the Plan and may be amended by the Company at any time for any reason without consent of any person except as otherwise provided by applicable law. *Appendix A and the Component Benefit Programs may be changed or replaced from time to time without formal amendment to the Plan.*

Medical Plan

Dental Plan

Vision Plan

Short Term Disability Plan

Long-Term Disability Plan

Life and Accidental Death and Dismemberment Insurance Plan

Business Travel Accident Plan

Employee Assistance Plan

Health Flexible Spending Account

APPENDIX B

Service Providers & Contact Information

COMPONENT BENEFIT PROGRAM	SERVICE PROVIDER	CONTACT INFORMATION
Medical	CareFirst	844-405-2160
Prescription	ExpressScripts	800-211-8497
Dental	Delta Dental	800-932-0783
Vision	EyeMed Vision Care	866-723-0513
Short-Term Disability	Sedgwick	877-524-6594
Long-Term Disability	Prudential (until 2020) Unum (as of 2020)	800-524-0542 800-421-0344
Life and AD&D	Prudential (until 2020) Unum (as of 2020)	800-524-0542 800-421-0344
Business Travel Accident	Zurich	866-841-4771
Health Flexible Spending Account	Further	866-758-6119
Employee Assistance Plan (EAP)	ComPsych (until 2020) Unum (as of 2020)	800-311-4327 800-421-0344
3 rd Party Benefit Enrollment	Hodges-Mace	404-574-6110
COBRA	CareFirst Administrator (until 2020) ConnectYourCare (as of 2020)	844-405-2160 855-687-2021

This Appendix B may be changed or replaced from time to time without formal amendment of the Plan.

APPENDIX C

Component SPDs

This Appendix C may be changed or replaced from time to time without formal amendment of the Plan.

APPENDIX D

Adopting Employers

This Appendix D may be changed or replaced from time to time without formal amendment of the Plan.

Perdue Transporation Inc
Perdue Foods LLC
Perdue AgriBusiness LLC
Perdue AgriRecycle LLC
Perdue Premium Meat Company, Inc. (Niman Ranch Inc)
Perdue Agribusiness Grain LLC
Sioux-Preme Packing Co.